November 1961

Mental Hospitals

Hospital Journal
of the American Psychiatric Association

THE MENTAL HOSPITAL SERVICE 1961 GOLD ACHIEVEMENT AWARD WINNER

. . . *See Page* 5

olume 12 Number 11

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Mental Hospitals

Hospital Journal of the

AMERICAN PSYCHIATRIC ASSOCIATION

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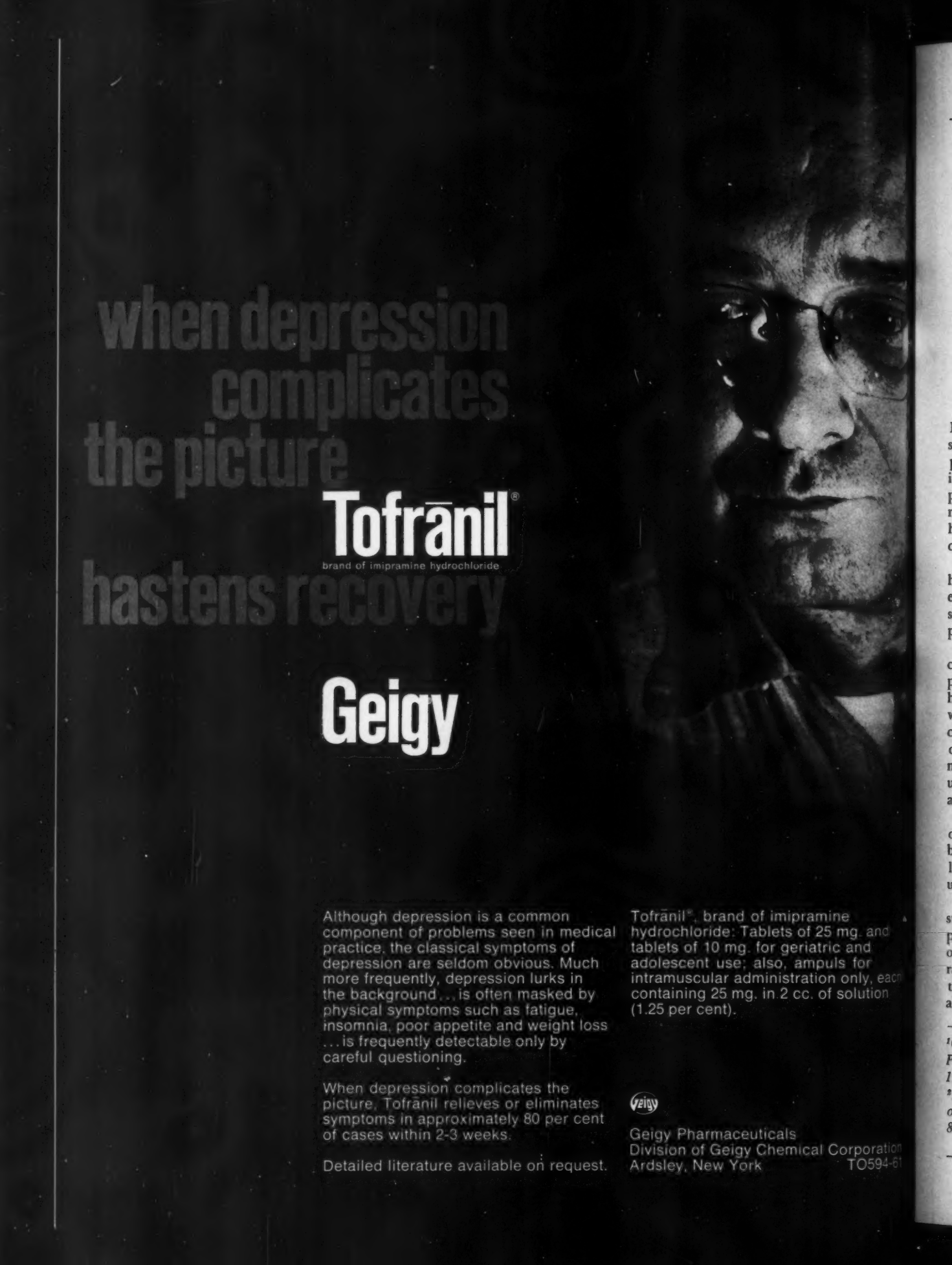
MENTAL HOSPITALS offers a forum for free discussion about matters of interest to persons involved in the care and treatment of psychiatric patients. Opinions expressed by the authors are theirs and do not necessarily represent the official policy of the American Psychiatric Association.



Although depression is a common component of problems seen in medical practice, the classical symptoms of depression are seldom obvious. Much more frequently, depression lurks in the background . . . is often masked by physical symptoms such as fatigue, insomnia, poor appetite and weight loss . . . is frequently detectable only by careful questioning.

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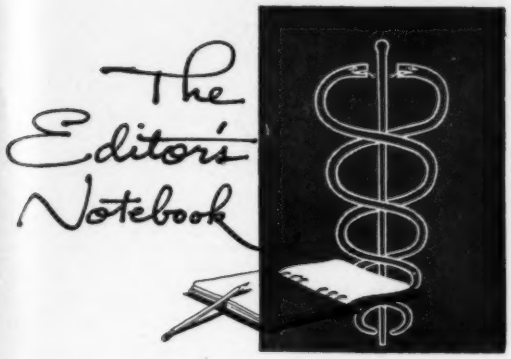

It is possible for us to establish a symbiotic relationship between the personal needs that brought us into psychiatry and the public needs for psychiatric service. Recently, a young physician about to enter his psychiatric residency visited the Central Office and reminisced vividly about the year of internship he had just completed in the emergency room of a large city hospital.

"Medical practice will never be so tough again," he said. "I saw human nature at its worst in that emergency room. I got so weary of the blood, the screaming, the accidents, the smell of cheap vino, the prostitutes, the drug addicts."

So many of the experiences he described will recur one way or another throughout his career in psychiatry. What better training can a psychiatrist have than to spend some time dealing with people who are desperate? So many of the emergencies he encounters are in fact psychiatric emergencies. Can we claim that street accidents, shootings, knife-fights have no underlying psychopathology? The intern gives urgently needed service, while at the same time he acquires painful but invaluable experience.

Today, psychiatric residents are beginning to receive comparable but specialized experience in a number of psychiatric emergency services, found mainly in large cities. These services have been set up to meet urgent public needs.

The Bronx Municipal Hospital Center, for instance, mans an emergency psychiatric center with psychiatric residents from the Albert Einstein School of Medicine[1] and offers a wide variety of services, ranging from electroshock and quick supportive therapy to continued follow-up service for ex-patients and ambulatory schizophrenics, and includes immediate psychiatric consultation to various social service agencies in the area. The Trouble-Shooting Clinic at the City Hospital,[2] Elmhurst, New York, does not restrict itself to emergencies, although it has its share of these. But it offers genuine preventive medicine by encouraging troubled people to come 24 hours a day for advice on marital problems, job difficulties, and the other vexing, ordinary problems of everyday living. Its psychiatrists learn to make swift and usually accurate judgments as to the early signs of serious mental disturbance and to refer the individual if need be for intensive treatment.

An unusual and world famous plan is operated by Dr. A. Querido in the city of Amsterdam.[3] This plan provides for 22 health centers in a city of 900,000 people, with a psychiatrist on duty in each center on a 24-hour basis. This psychiatrist must make a home visit to any family reporting a psychiatric emergency. Thus, both he and his social worker can observe at first hand the full family background of the conflict.

A plan that is near to me geographically and personally is the psychiatric emergency service set up by the Washington Psychiatric Society,[4] my local District Branch. Supported by congressional funds, private psychiatrists will visit an indigent family reporting a psychiatric emergency at any hour of the day or night. No treatment is given, but referrals are made if necessary, and the attending psychiatrist is prepared to give testimony if there is a police action involved.

If any psychiatric facility is to receive solid, meaningful community support, it must be prepared to meet the needs of the community. Today, the demand is for the type of service long rendered by general hospitals in medicine, surgery, and obstetrics. The few centers I have described meet the demand for psychiatric service and may point directions which others may explore. Many more such centers are needed—connected with general and psychiatric hospitals, health and welfare agencies, and other public services. Residents could learn much by doing a "psychiatric internship" in these centers. More grants are needed to evaluate the results of the methods that develop in them.

The community's needs come first— our personal needs to serve, to learn, to teach come later. Fortunately for us all, these needs are complementary.

Matthew Ross, M.D.

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[1] *Coleman, M. Donald: Problems in an Emergency Psychiatric Clinic, Mental Hospitals 11(5):26-27, May 1960.*

[2] *Bellak, Leopold: A General Hospital Becomes a Focus of Community Psychiatry, Mental Hospitals 12(9): 8-10, Sept. 1961.*

[3] *Baars, Conrad W.: The Amsterdam Plan, Mental Hospitals 10(5):18-19, May 1959.*

[4] *District Branch News: District of Columbia— Psychiatric Service for Low-Income Families, Mental Hospitals 12(8):18, Aug. 1961.*

ACHIEVEMENT AWARDS '61— PROFILES IN PROGRESS

By HAROLD R. MARTIN, M.D.
Section of Psychiatry
Mayo Clinic
Rochester, Minnesota

CHOOSING THE RECIPIENTS of the Mental Hospital Service Achievement Awards is always a difficult task, but it has been especially difficult this year because of the many applications reporting an unusually large number of worthy projects. Many excellent programs could not be recognized this year—and this, in itself, is indicative of the improvement wrought in psychiatric hospital operation during the past decade.

When the Awards program was first established in 1949, recognition usually was given to institutions that, despite terrible handicaps, had been able to improve greatly one phase of hospital service. In those days, it took tremendous energy and ingenuity—plus an occasional small miracle—simply to run a "good" psychiatric hospital. True, most hospitals still operate under formidable handicaps, but they have many more dedicated, capable staff people. A hospital's ingenious teaching methods, new ways of stimulating chronic patients, or effective public relations program are not enough to warrant recognition when so many hospitals are operating comparable programs.

Today, the really significant steps forward do not consist of doing a good job of running a conventional hospital, but of devising new ways of approaching the whole problem of treating the mentally ill. This was the rationale behind the choices the 1961 Awards Committee made. It does not mean, of course, that small but important projects should not be recognized in the years to come, but this will be a problem for future committees.

The Achievement Awards Committee is a subcommittee of the MHS Board of Consultants. With the assistance of Dr. Robert S. Garber as a special consultant, members of the 1961 Committee assumed responsibility for establishing policies, procedures, and criteria which the Board has approved. At the request of the Medical Director and through the cooperation of the past Speaker of the Assembly, Dr. John Saunders, and the present Speaker, Dr. Edward J. Billings, district branch representatives have made personal visits to investigate the programs for which award applications were made. Their thoughtful reports and the additional information they supplied were of the utmost help to the Committee in making the final decisions. The Committee believes that personnel in the psychiatric facilities they visited have realized the truth of the statement made by Dr. Billings in the August issue of *Mental Hospitals:* "Most mental hospitals have a specific district branch to which they can turn for counsel and support."

The 1961 Awards Committee had its final meeting in Omaha during the 13th Mental Hospital Institute, and as outgoing chairman, I made our report to the Board of Consultants. Hereafter, I understand, each chairman will serve for one year only and will be succeeded by the next senior member of the Committee. My own half-life expired at the 13th Mental Hospital Institute when I handed my nonexistent gavel to Dr. Stewart T. Ginsberg, the 1962 Chairman. With him will be Dr. Hayden Donahue and the newly appointed member, Dr. I. H. MacKinnon. I have enjoyed my two-year term as chairman.

Mathew Ross, M.D., APA Medical Director, presented the 1961 Achievement Awards immediately after the 13th Mental Hospital Institute annual dinner. To the left of the picture is D. E. Zarfas, M.D., Superintendent of The Psychiatric Research Institute for Children, London, Ontario, which won the Bronze Award; Dr. Mathew Ross; Robijn Hornstra, M.D., Clinical Director, Greater Kansas City Mental Health Foundation, winner of the Gold Award; and Lester Rudy, M.D., Superintendent of the Illinois State Psychiatric Institute, Chicago, who accepted the Silver Award for his hospital.

The very location of Greater Kansas City Mental Health Foundation is a far cry from the old isolated mental hospital. Here nurses watch patients playing volleyball against a background of city skyscrapers, parkland, and the Center Building.

GOLD AWARD

is given to the Greater Kansas City Mental Health Foundation for the development by this relatively small psychiatric facility of efficient, short-term psychiatric services in an urban area, which a few years ago had less than minimal mental health resources. In choosing this program, the Achievement Awards Committee reflected the modern trend toward hospital-community participation in a total psychiatric treatment program.

KANSAS CITY'S PSYCHIATRIC RECEIVING CENTER is a 70-bed hospital where approximately 600 inpatients and 1,400 outpatients are treated every year. This astonishing utilization of a relatively small facility is the result of community-hospital cooperation at its most productive level. It represents the successful development of efficient, short-term psychiatric treatment services in an urban area that, a mere dozen years ago, had less than minimal mental health resources.

In the late 1940's, Kansas City had only a handful of psychiatrists, a public program that consisted of two "snake pits"—one in each of its general hospitals; and the small Child Guidance Clinic. This poverty of services inspired the establishment of the Greater Kansas City Mental Health Foundation in May 1950. A regional, nonprofit organization, the Foundation became the parent of the Psychiatric Receiving Center and, since April 1954, has operated it as the core of an expanding community mental health program.

The Center is part of the city's general hospital system and its professional services are supplied by the Foundation, under contract with the city. Its professional and administrative staffs have developed a clear conception of what the relationship between a mental hospital and the community should be—and have acted upon it. They define the proper role of psychiatric treatment as intervention in a patient's areas of disturbed function while maintaining his abilities to function socially and participate in community affairs.

Voluntary Admissions in the Majority

The Center is available to patients for hospitalization when their disturbance is so great or their functioning so poor that they are not able to survive in the community without aid. The remarkable degree of agreement between patient, hospital, and community as to the need for hospitalization is apparent in a significant fact: more than 99 per cent of the ad-

missions to the inpatient service are voluntary in the specific sense that the patient signs his own admission papers. For these patients, the Center provides an environment sufficiently protected and structured to give them time and opportunity to reorganize their disordered behavior. At the same time, the availability of this environment is a response to the community's legitimate demand for its own protection.

The staff's goal for inpatients is to closely involve them therapeutically with the hospital's social system without cutting them off from the usual patterns of their lives. Even the organization of the wards reflects familiar aspects of the community. When the Center opened, the third floor was reserved for female inpatients, and the second floor for males. A few years later, segregation by sex was eliminated; the second floor became an admission ward and the third floor a predischarge ward. There has never been any racial segregation. This ward plan carries out the staff's belief that, because citizens of Kansas City live in a community composed of men and women both colored and white, a treatment setting that ignores or denies these facts is unrealistic. On both wards, patients keep and manage their own money, wear and care for their own clothes (the wards have automatic washing machines and ironing facilities), and are expected to manage the details of their daily lives. When reluctant or unable to do so, they are given assistance.

Physically, the admission ward is closed. However, the staff considers the "open door" to be a state of mind rather than a matter of locks. They encourage patients—even those who are acutely ill—to leave the hospital with friends and relatives to take short drives or attend to personal business, to receive visitors, and to engage in activities outside the hospital even before they are transferred to the open predischarge ward. These activities, conducted in public places and supervised by nursing personnel and volunteers, include bowling, picnics, entertainments, and sports events. Week-end passes are available to patients as soon after admission as their condition warrants.

Various organizations participate in the hospital's therapeutic programs. Volunteers, after training by the senior staff, work directly with the patients. In this way, they express the community's direct concern with the patients' welfare, and increase their own understanding of mental illness and its treatment.

Contribution of Psychotropic Drugs

The staff attributes the successful development of its programs to the existence and proven efficacy of psychotropic drugs. The drugs' power to control behavioral disturbances allows nursing personnel to devote more of their time to organizing and supervising therapeutic activities. Although the routine on the admission ward is well regulated so that patients may rapidly become oriented and resocialized, free time is an integral part of the program because it provides opportunities to test the patients' progress toward adequate functioning.

Patients move quickly from the admission ward to the predischarge ward and on to their homes and work. In 1960-61 the median length of inpatient stay was less than four weeks. Individual and group psychotherapy and other more prolonged therapeutic measures ordinarily are conducted *after* the patient returns to his home.

The day hospital provides treatment that, in many ways, is as intensive as the inpatient service. Most patients attend the day hospital for less than five days a week; the average patient attends for 22 days spread over a period of about six weeks

Another service conducted by the Center is the Medication Clinic which provides psychotropic drugs and an opportunity for patients to have brief interviews lasting from five minutes to a half hour. A more traditional outpatient service offers both individual and group psychotherapy for patients who can profit from these forms of treatment.

All sorts of normal community-type activities are part of the Center's program. Physicians, staff members, patients, volunteers join together for informal fun. Here Dr. Robijn Hornstra shoots a game of pool with a staff member and a patient.

The Center's successful short-term treatment has reduced per-patient costs and, more important, reduced the loss of time caused by personal dislocation when a person becomes mentally ill. In 1960, 1,200 acutely ill psychiatric patients received intensive services from a staff of five psychiatrists, 10 residents, 16 psychiatric nurses, 22 psychiatric aides, two clinical psychologists, four social workers, and three occupational therapists. The total budget for these services was about $400,000, and the average cost per patient was $311. This average includes a large number of patients who received relatively inexpensive outpatient services; in all likelihood, however, most of these would have required hospitalization if outpatient services had not been available.

The program is as effective clinically as it is economically. Periods of total psychiatric disability are short. All patients are selected on the basis of the acuteness and severity of their illnesses; 81 per cent of the admissions in 1958-59 were psychotic (including functional and organic), and 19 per cent were neurotic or had character disorders. The Center's readmission rates compare favorably with those of other psychiatric facilities. In 1958-59, the rate of readmission to inpatient service was 29 per cent within a year after discharge. There were fewer readmissions to other less intensive services.

In addition to the Psychiatric Receiving Center, the Mental Health Foundation sponsors the Department of Child Psychiatry which provides diagnostic and treatment services to children in the metropolitan area and Wyandotte County. These services are dispensed through the Child Guidance Clinic, The Child Research Council, and arrangements existing between the Foundation and various hospitals and children's homes.

Diversified Research

The Foundation also conducts an extensive research program, supported by funds from the National Institutes of Health and the Kansas City Association of Trusts and Foundations. Projects include one dealing with the differential effects of tranquilizing drugs with the objective of providing a more rational and effective choice of drugs for psychotic patients, one seeking a means to detect emotional disturbances in school children and to offer remedial measures within the school before delinquency and severe psychological problems ensue, and one to develop techniques for detecting hardening of the major arteries of the brain before irreparable damage is done.

Other projects include research to detect brain damage in children—damage that may result in severe behavioral problems—and to develop effective control of such behavior; studies to determine the routes followed by and the sources of entrance of patients to the Psychiatric Receiving Center with an eye toward estimating future mental health needs; and a line of investigation being developed toward a more efficient use of the facilities at the Center so that progressively better care may be developed at the lowest possible cost.

Aside from its broad services to the community's mentally ill persons, the Foundation also is making a contribution to psychiatry as a whole by offering many opportunities for training. Currently, 10 psychiatric residents and two fellows in child psychiatry are receiving professional training. Student nurses from three hospitals spend 13 weeks in psychiatric nursing at the Psychiatric Receiving Center; graduate social workers from the Universities of Kansas and Missouri receive accredited field training in the Department of Child Psychiatry; and graduate psychology students from the Universities of Kansas City, Oklahoma, Missouri, and Kansas serve psychological traineeships in the department.

Half of the senior class of the University of Missouri School of Medicine receive six weeks of clinical training in psychiatry. Police officers from the city's police department attend a 12-hour training course in the practical aspects of psychiatry as related to understanding mentally ill people; groups of 18 are exposed to this training every month.

Highlights in Foundation Progress

Without the Foundation there would not have been the number and quality of professional psychiatric personnel to provide the highly skilled, intensive treatment which is available now. Psychiatric illness would have progressed further in the majority of cases, been more resistant to treatment, and been of longer duration. More seriously ill psychiatric patients would have had to compete with patients from all over the state for the limited number of places available in the state's mental hospitals. Many would have spent long waiting periods in the city's jail or in custodial wards in the city's hospitals—wards already crowded and without adequate professional staff. Once in the state hospitals, patients would have received less intensive treatment from psychiatric personnel who, although skilled and dedicated, are swamped and professionally harried by the large number of patients under their care.

Without the Mental Health Foundation, the economically less fortunate people of Kansas City would have had to wait longer to receive less intensive and less effective treatment while their psychiatric illnesses progressed and became more resistant to treatment. The deterioration of family circumstances would have advanced more rapidly. Prolonged involvement with mentally ill parents and spouses would have done irreparable damage to other members of families and to the whole community. In many cases, acts of violence, destruction, or suicide would have gone unprevented because no early treatment was open to those who obviously needed care and attention. Most important, without the children's services the community could not have joined forces to prevent severe mental illnesses in the adults of tomorrow. •

The well-equipped laboratories carry out basic research, but clinical studies form an equally important part of the research program.

SILVER AWARD

is given to the Illinois State Psychiatric Institute for widespread influence on the care of the state's 50,000 mental patients. Since its opening in July, 1959, the Institute has become the keystone for the improvement of clinical services and for teaching and research programs within the 12 hospitals operated by the state's Department of Mental Health.

DURING THE FIRST TWO YEARS of its existence, the Illinois State Psychiatric Institute in Chicago has had widespread influence on the care of the state's 50,000 mental patients. It has become the keystone for the improvement of clinical services and for teaching and research programs within the 12 hospitals operated by the state Department of Mental Health. A product of close cooperation between the department and the five medical schools and two psychiatric institutes in Chicago, the Institute was opened on July 14, 1959.

A modern, air-conditioned, 434-bed hospital, the Institute is accredited by the Joint Commission on Accreditation of Hospitals. At present, there are 300 inpatients representing all kinds of syndromes. The approach to treatment is basically one of social orientation, with particular emphasis on the newer techniques of the therapeutic community, rehabilitation, and use of treatment units or teams. The maximum period of hospitalization is six months, and the discharge rate is surprisingly high with relatively few readmissions.

The resident program has received three-year approval by the American Medical Association Council on Medical Education and Hospitals. The Department of Education is responsible for improving training standards in all areas of psychiatry and the allied disciplines in the state system. This hospital is the center for psychiatric residency training for the entire state and now has 53 residents in training. Each resident, during his three years of training, is constantly urged to take an interest in the care of the chronically ill as well as the acutely ill. This emphasis is increased by having him spend his second year of training in one of the state institutions, where he is responsible for a prolonged-care ward.

Teams of individuals from the Institute and the five participating medical schools teach in the state hospitals. The Institute's director of education assigns a particular state hospital to each medical school and to the Institute itself. This type of affiliation has increased the interest of the participating faculty and stimulated hosptial staffs to improve their therapeutic milieus.

In October 1960, the Institute initiated a four-week course for state hospital physicians. The course includes lectures, clinical supervision, and case demonstrations. A maximum of 12 physicians, chosen by their institutions, are accepted for each class. Participants are at the Institute full-time while taking the course, which is given twice a year.

Coordinated Education Programs

The Institute's director of education also works with the Departments of Social Service, Psychology, Nursing Education, and Activities to further the statewide program in these disciplines. The psychiatric staff has participated in seminars and supervision at the state hospitals. New programs embodying revised concepts of the open hospital, the therapeutic community, and day and night hospitals have been established, and Institute personnel gives instruction in these techniques to state hospital staffs.

Each of the Institute's service chiefs has faculty status at one of the medical schools, and acts as liaison between the schools' departments of psychiatry and the Institute. The schools send medical students to the Institute for their clerkships; this is a step toward the goal of helping general practitioners to acquire basic psychiatric skills and to inspire more medical students to elect this specialty.

The Social Service Department provides educational programs at the Institute and its personnel participate in professional workshops and advanced training programs at the state hospitals. It has a student-training division on both master and doctoral levels of graduate study. Through this department, all three schools of social work in Chicago, for the first time, are actively coordinating their educational programs with personnel from the state hospitals.

The Nursing Department's main goal is to improve psychiatric nursing in Illinois. The director and nine of her staff have masters' degrees, and 40 nurses have bachelors' degrees. The department's supervisor-educator groups are identifying and implementing methods of nursing care that will be more therapeutic in practice and, hopefully, will become a model for nurses in other hospitals. The staff is also changing centralized systems that are nontherapeutic and restrictive for patients. Clothing and laundry procedures are among those that have been altered in order to introduce desirable modifications throughout the state.

The Nursing Department conducts workshops and offers consultation services to the state hospitals in supervision, teaching, and administration. All of its members, at supervisory level, are required to write at least one paper a year about the department's work. These papers are presented to local nursing leaders and to state hospital nursing personnel during seminars; then they are duplicated and circulated.

In order to improve and standardize medical recording in the state hospitals, clerical personnel from the medical records departments of 13 institutions attended a four-week course at the Institute. This course included lectures and demonstrations in the analysis and use of psychiatric medical records, microfilming, legal and ethical responsibility, statistics, and medical terminology. It will be repeated annually.

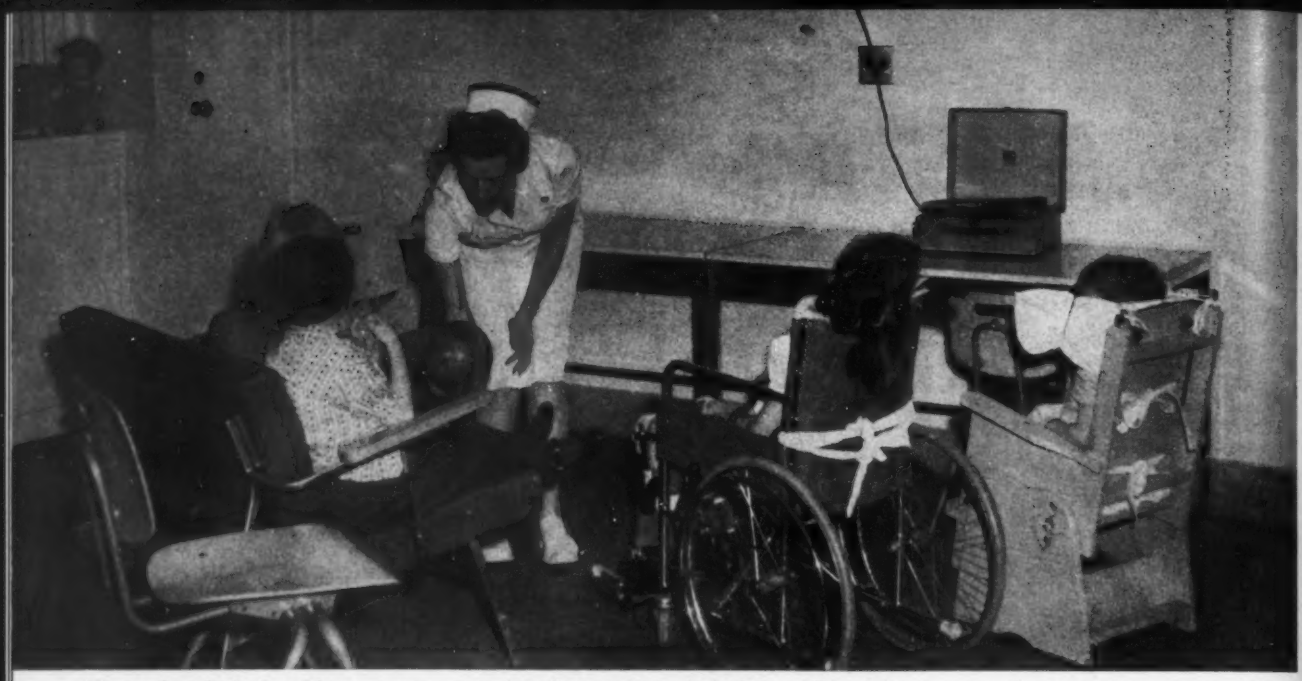
Accent on Research

Comprehensive research studies are progressing in the Institute and also in several outstanding laboratories under Institute supervision. Patients from other state hospitals have been transferred to the Illinois State Psychiatric Institute for elective neurosurgery in an attempt to discover how to control the behavior of the chronically disturbed. Clinical research in the form of drug evaluation studies has been completed with both inpatients and outpatients. In addition, a group of chronically ill patients at the Chicago State Hospital participate in drug studies which are carried out jointly by the staffs of the hospital and the Institute.

An active Outpatient Department provides aftercare for the Institute's patients and serves as a community treatment center; by June 30, 1961, the number of aftercare patient-visits totalled 1,464 and community patient-visits, 6,405. The services of this department are available to the entire state, and difficult diagnostic entities have been referred to it from state hospitals for evaluation and supervised therapy. The Outpatient Clinic also trains members of the state hospital staffs and clerks from participating medical schools.

The Psychiatric Institute now has a staff of 17 full-time and 49 part-time Board Certified psychiatrists, 124 nurses, 29 social workers, 16 activity therapists, and seven psychologists. Its staff and visiting lecturers have presented 38 telecommunication teaching programs for the benefit of state hospitals. •

Residents share their staff meetings with nurses and other personnel. Everybody learns, and communication is facilitated.



Nurse plays lovingly with youngsters; note ingenious support devised for child (right) in an ordinary wooden nursery chair.

BRONZE AWARD

is given to the Psychiatric Research Institute for Children, London, Ontario, for the three separate areas of its program: first, for the service given to mentally deficient or suspected mentally deficient patients of all ages in southwest Ontario; second, for the research which the Institute is conducting in conjunction with the University of Western Ontario Faculty of Medicine; and finally, for the teaching conducted by the Institute staff at University, professional, and nonprofessional levels.

THE CHILDREN'S PSYCHIATRIC RESEARCH INSTITUTE, London, Ontario, is the first community-centered psychiatric hospital for retarded children in the province. It was established by the Mental Health Branch of the Ontario Department of Health, as part of the "new look" program initiated by Dr. M. B. Dymond, Minister of Health. The philosophy behind the Institute is that an intellectually impaired child has a right to total understanding of his problem as it relates to himself, his family, and his community; that the assets of the child, the family, and the community should be marshalled to assist him in developing to his maximum potential; that he should not be isolated in an institution, but, when possible, should remain at home and be regarded as the community's responsibility; and that these goals should be realized through individual, family, and community guidance.

The Institute began functioning as an outpatient clinic on February 1, 1960, in the Pratten Pavilion of the Beck Memorial Sanatorium. Eventually, it will occupy the entire sanatorium, which has been purchased by the Province of Ontario, when the new, smaller, and more economical Chest Diseases Hospital has been established elsewhere in London. The inpatient service commenced on February 1, 1961.

The utilization of this existing facility for the study and treatment of mental retardation is the result of the remarkable interest displayed by the Faculty of Medicine of the University of Western Ontario and by governmental and parental groups. Ontario faces the same problems with the mentally retarded that exist all over North America; that is, overcrowded training and hospital schools, lack of trained personnel, and professional apathy. It is hoped that this new community-oriented treatment and research approach to the problems of the retarded will help to overcome the prevailing nihilistic philosophy surrounding the prevention and treatment of mental retardation.

The Institute's program is divided into three separate areas:

1) *Service* to mentally retarded patients, or those

**Nomenclature on page 10 is that proposed by the American Association on Mental Deficiency.*

suspected of being mentally retarded, of all ages. However, the patients, for the most part, are children from an area in southwestern Ontario that, in 13 counties, contains a population of 1,200,000, approximately 3 per cent of whom are intellectually handicapped.

2) *Research* conducted in conjunction with the University of Western Ontario Faculty of Medicine.

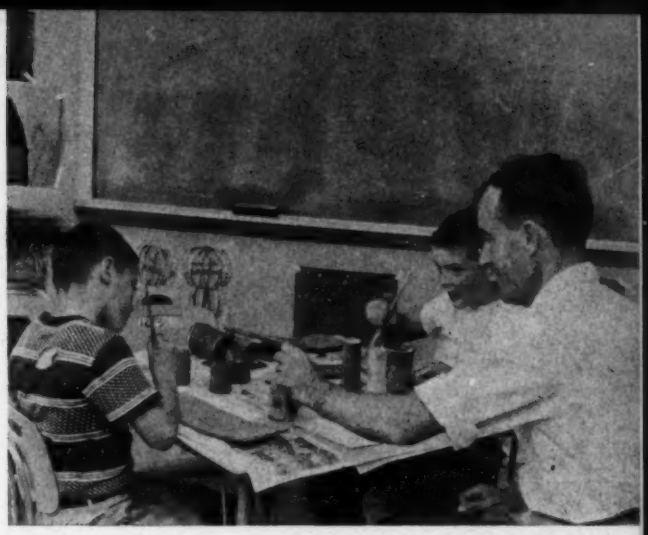
3) *Teaching* conducted by the Institute staff at university, professional, and nonprofessional levels.

Patients are referred to the Institute by physicians or recognized social agencies. This stipulation is made in order to establish a community contact and maintain it when the patient completes his evaluation. In addition, the Institute sponsors a program—another "first" in the province—of preadmission screening to Ontario hospital schools, which are similar to state training schools in the United States. Screening involves complete evaluation of mentally retarded patients for whom long-term institutional care has been requested. It is helpful to many patients' families who are not familiar with available hospital facilities and have not had an opportunity to discuss and resolve their feelings about having a retarded child.

Definitive Diagnosis

By September 30, 1961, 664 patients had been assessed in the outpatient department and 185 in the inpatient department. (Most of the latter had already been assessed in the outpatient department and were admitted for further diagnosis, observation, or in order to give their parents short-term relief.) A patient's average length of stay is 34 days, although some are admitted for longitudinal study. The following breakdown shows the types of disorders and the number of patients treated for each:

Encephalopathy, congenital, associated with pre-natal infection	4 cases
Encephalopathy, due to postnatal cerebral infection	35 cases
Encephalopathy, congenital, associated with toxemia of pregnancy	3 cases
Encephalopathy, congenital, associated with other maternal intoxication	2 cases
Bilirubin encephalopathy (Kernicterus)	12 cases
Post-immunization encephalopathy	1 case
Encephalopathy, other, due to intoxication	1 case
Encephalopathy due to prenatal injury	14 cases
Encephalopathy due to mechanical injury at birth	50 cases
Encephalopathy due to asphyxia at birth	17 cases
Encephalopathy due to postnatal injury	15 cases
Phenylketonuria	6 cases
Encephalopathy associated with other disorders, protein metabolism	2 cases
Hypothyroidism	1 case
Encephalopathy, other, due to metabolic growth or nutritional disorder	10 cases



Boys enjoy the company of men, especially in such masculine activities as toymaking and finishing done with the therapist.

Below: every possible diagnostic test is done on each child; psychological tests come later but are never neglected.

Neurofibromatosis (Von Recklinghausen's Disease)	1 case
Trigeminal cerebral angiomatosis (Sturge-Weber-Dimitri's Disease)	3 cases
Tuberous Sclerosis	1 case
Intracranial Neoplasm, other	4 cases
Cerebral defect, congenital	98 cases
Encephalopathy associated with primary cranial anomaly	14 cases
Mongolism	77 cases
Other, due to unkown prenatal influence	15 cases
Mental Retardation associated . . . due to unknown or uncertain cause with structural reactions manifest	36 cases
Mental Retardation due to uncertain (or presumed psychological) cause with the functional reaction alone manifest	153 cases
Casess not classifiable because of normal intelligence	36 cases

In the outpatient service, a patient, his family, and his milieu are assessed by a multidiscipline team of psychiatrists, pediatricians, psychologists, social workers, teachers, and nurses. Other specialties, including speech pathology, radiology, audiology, ophthalmology, orthopedics, neurology, endocrinology,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From the Literature

Excitement Following Electroconvulsive Therapy

Murray[1] administered parenteral SPARINE (with atropine sulfate, succinylcholine dichloride, and a barbiturate) to 50 patients prior to electroconvulsive therapy. Observations were conducted during 497 individual treatments.

The salutary effects of SPARINE, which Murray attributes to enhancement of barbiturate action, were evident in improved behavior, diminution of agitation following treatment, and prolongation of sleep. No significant blood pressure fluctuations or cardiovascular abnormalities were noted in any of the patients.

Excessive Psychokinetic Activity

Graffeo[2] selected 180 chronic, hospitalized psychotic patients at random on the basis of increased psychokinetic activity manifested by restlessness and agitation, or complications or lack of improvement with other chemotherapeutic modalities.

SPARINE was administered orally in dosages graded to the psychokinetic activity of the patient.

Of the 180 patients, 72 percent showed marked to moderate improvement in behavior, and no patient's behavior worsened. Almost half of the patients showed marked to moderate improvement in their psychoses; in 3 percent mild regressive tendencies were noted. According to the author: "Promazine [SPARINE] adequately modified the formerly disturbed behavior pattern of the chronic schizophrenic patients so that psychotherapy was facilitated and, as a result, made it possible for 26 patients to be released from the hospital."

Alcoholism

Figurelli[3] has found that the use of SPARINE in uncomplicated cases of acute alcoholism controlled symptoms of active delirium, as well as nausea and vomiting, and drastically reduced mortality rates. According to Figurelli ". . . medication with promazine [SPARINE] enables more rapid control of delirium, eliminates the prolonged and more expensive therapeutic measures which formerly were the only recourse . . . and permits earlier return of the patient to gainful occupation." Parenteral SPARINE is usually used initially by Figurelli; oral SPARINE is used for maintenance. No precipitous drop in blood pressure occurred in the series of patients studied by Figurelli.

Note: The degree of central nervous system depression induced by SPARINE has not been great; however, in the acutely inebriated person the initial dose should not exceed that recommended to be sure that the depressant effect of alcohol is not enhanced. SPARINE should not be used in comatose states due to central nervous system depressants (alcohol, barbiturates, opiates, etc.). In patients with cerebral arteriosclerosis, coronary heart disease, or other conditions where a drop in blood pressure may be undesirable, SPARINE should be used with caution.

References

1. Murray, N.: Diseases of Nervous System *21*:1 (Aug.) 1960.
2. Graffeo, A.J.: Am. J. Psychiat. *116*:842 (March) 1960.
3. Figurelli, F.A.: J. Am. Med. Assoc. *166*:747 (Feb. 15) 1958.

For further information on limitations, administration and prescribing of SPARINE, see descriptive literature or current Direction Circular.

cytogenetics, and biochemistry are utilized when indicated. Specialists in the latter fields are all on the staff of the University of Western Ontario. A pediatrician or psychiatrist is in charge of each case, depending on the presenting problem, but this case responsibility may change after the evaluation conference is held.

The staff makes an exhaustive effort to arrive at an etiological and pathological diagnosis of the cause of each patient's mental retardation. They evaluate a patient's present level of intellectual and emotional functioning and estimate his potential for future development. Either the superintendent or the clinical director begins a patient's evaluation by discussing his need for outpatient treatment with the referring community agency or physician.

The first contact with a patient's family is made under the direction of the Social Work Department. This is done directly by the physician or by community health agencies under his guidance. The physician obtains data from previous investigations and hospitalizations, birth histories, school reports, and psychiatric social histories before the rest of the team sees a patient. When advisable, the Institute's teaching staff visits a patient's school in order to see him in this setting; this observation later makes it possible for them to guide the teacher in managing the child.

Admission Technique

When a patient and his parents arrive at the Institute, they immediately are directed to a physician who spends an average total of five hours interviewing the parents and giving the child physical and neurological examinations and observing him in play or other activities. While the doctor interviews the parents, the child receives psychometric tests from a psychologist. Projective techniques are utilized if necessary. Each child also is assessed in a play session by a physician and others who observe him by means of closed-circuit television. The parents frequently are asked to comment on their child's activity while they observe him through this medium.

Technicians perform routine laboratory studies, including complete urinalysis as well as examination for reducing sugars and phenylketonuria, and complete blood examination. They use special techniques to screen urine aminoacids, make buccal smear scrapings for studies of sex chromatin, and do chromosome studies. A patient's skull and wrists are routinely X-rayed for both diagnosis and research purposes.

When the evaluation is completed, the Institute assists the parents to plan the best course for their child's immediate and future management and provides long-term guidance or individual and group psychotherapy for both parent and patient.

The Institute's first inpatient ward accommodated 15 patients in single- and two-bed rooms in a two-story building. In September 1961, 100 additional beds became available in two renovated buildings. There are ample day-care and activity areas. The inpatient staff includes seven registered nurses, 16 nurse's aides, and three hospital attendants.

The inpatient department gives the outpatient team an opportunity to:

1) Examine children in a residential setting.
2) Examine patients on a 24-hour basis in order to clarify diagnoses.
3) In special cases, to admit a patient's mother in order to study the mother-child relationship. In such cases, the mother directs the daily management of the child.
4) Attempt special treatment.
5) Provide short-term relief by admitting a child when there is unusual stress at home, where the family needs a holiday, or when family members require assistance during their own psychotherapy.

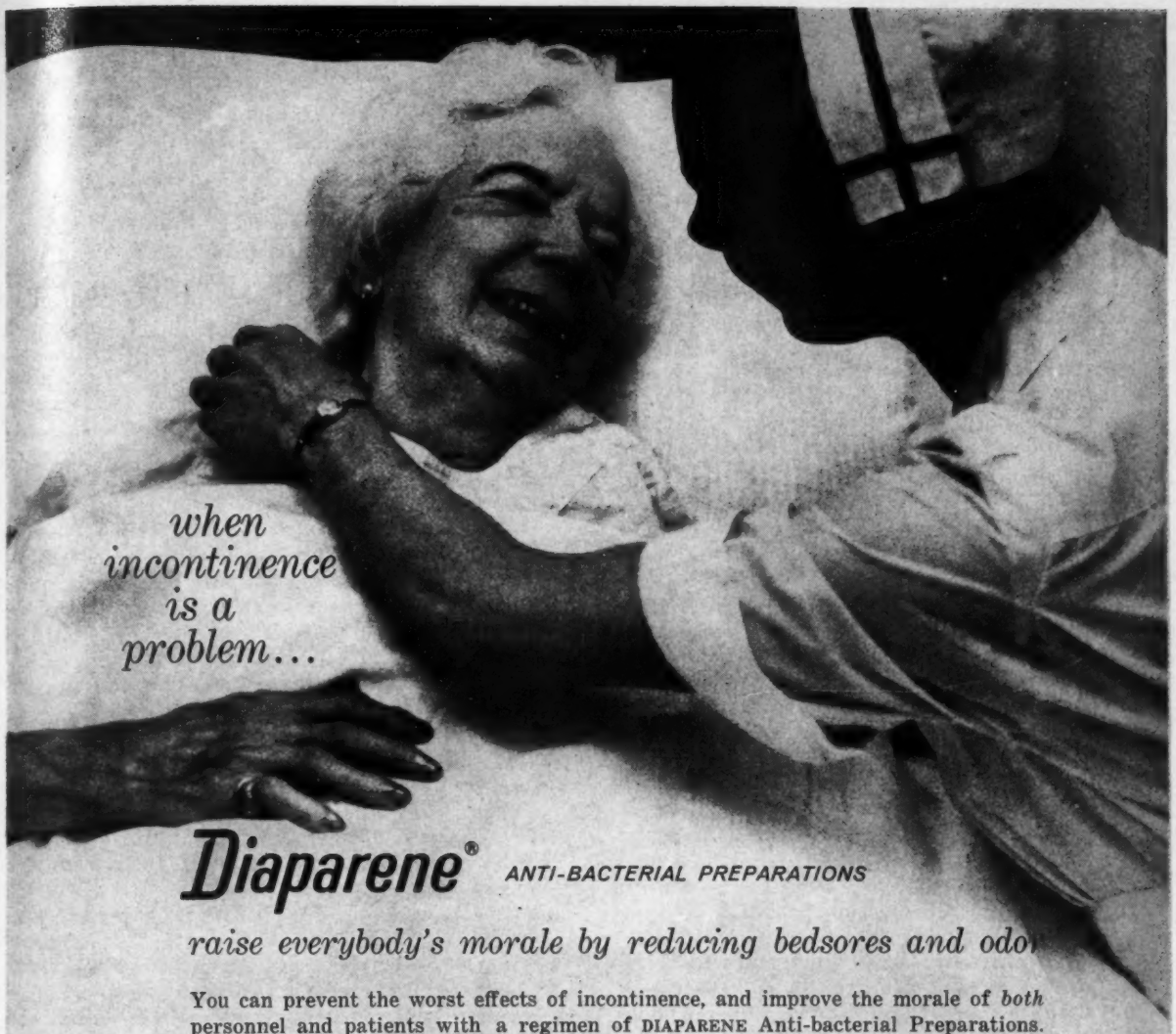
One of the more exciting and stimulating functions of both services is to provide a group of patients for extensive research. Research at the university and at the Institute is coordinated by the Research and Training Advisory Committee. Projects include investigations in the fields of cytogenetics, endocrinology, biochemistry, epidemiology, psychiatry, social work, and psychology.

For example, Dr. W. C. Murray, consultant in biochemistry, is engaged in research to determine chemical and metabolic deviations in mentally retarded patients. Biochemical examination of one patient recently resulted in the isolation of a new inborn error of metabolism (citrullinuria). Drs. Murray L. Barr and David H. Carr, consultants in cytogenetics, are studying sex chromosomes of a group of pateints with Klinefelter's Syndrome and chromosome abnormalities in mongoloid patients.

Philosophy Extended through Training

The philosophy of definitive diagnoses and appropriate treatment as embodied in the goals of the Institute are related to professional and lay groups in several ways. Institute staff members give lectures on mental retardation to third-year medical students and hold clinics for fourth-year medical students. The lectures are available on 30-minute tape recordings from the Canadian College of General Practice. Postgraduate psychiatric training began on July 1, 1961, involving a six-month, full-time training period at the Institute in partial fulfillment of the students' academic requirements.

Almost daily, community professional personnel attend Institute case-conferences to discuss their problems. The Institute's staff has held meetings with general practitioners, pediatricians, and psychiatrists. During the past year, staff members also gave talks on clinic function and mental retardation to service clubs, parents' association locals, and provincial groups. Their articles have appeared in national and regional newspapers, magazines, and professional journals.



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*Shovlain, F. E.; Brown, R. W.; Delaney, G. A.; and Lelli, F. P.: Hospitals *33*:61 (June 1) 1959.

Have You Heard?

PATIENT-VOLUNTEER SERVICE PROJECT– At Brooklyn State Hospital, N. Y., a program has been developed by which patients may leave the hospital grounds and work as volunteers for community agencies. Since the program began three years ago, 150 patients have been assigned as volunteers to work for the Brooklyn Tuberculosis and Health Association. According to Mrs. Wallace B. White, the Association's president, this program has proven mutually beneficial. The patients live at the hospital and commute to the Association's office by bus. The Association pays each patient $2 per day for transportation and lunch. The patient must stay in the program from six to 12 months, during which the hospital staff continually evaluates his progress and subsequently determines if he is suitable for additional training or for job placement.

SEMINARS ON MENTAL HYGIENE–North Shore Hospital, Winnetka, Ill., will sponsor four seminars on the theme, "Mental Hygiene—A Challenge to You and the Community." The seminars are being conducted as a public service by the hospital. Among the participants will be David M. Rioch, M.D., director, Neuropsychiatric Division, Walter Reed Army Institute of Research, Washington, D. C.; Vladimir G. Urse, M.D., director, Cook County Mental Hygiene Clinic, Ill.; Milton A. Dushkin, M.D., medical director, North Shore Hospital and faculty member, Department of Psychiatry, Northwestern University; and Helen B. Carlson, M.D., professor of psychiatry, Northwestern University and Roosevelt College.

EMPLOYER RESISTANCE TO DISCHARGED PATIENTS–Harvey E. Wolfe, M.D., of Longview State Hospital, Cincinnati, Ohio, conducted a survey to determine if top manufacturing-firm officials would hire discharged mental patients. Forty-four per cent of the officials from the larger firms (employing 100 to 14,000 workers) and 55 per cent from the smaller concerns (less than 100 employees) indicated that they would be interested in hiring discharged mental patients. Only eight per cent of the officials from the large manufacturers and seven per cent from the small said that they would not consider employing ex-patients.

INTERNSHIP IN CLINICAL PSYCHOLOGY– In September, Milledgeville State Hospital, Ga., received its first intern in the field of clinical psychology. To be accepted by the hospital as an intern in this field, the student must be in his second year of graduate study, must have completed the required number of clinical courses and practicum training, and must have been accepted by a university as a doctoral candidate in clinical psychology. Interns will spend alternate quarters at the hospital for two years, thereby completing the requirement of one full year of internship. Academic credit will be given by the university for the internship and for advanced courses of study taken at the hospital. Interns receive a stipend during their work at the hospital.

SCHOOL OF PRACTICAL NURSING—The New York State Department of Mental Hygiene has established a school of practical nursing, located at Willowbrook State School on Staten Island. The first class of approximately 35 students began studies in September. Instruction in the techniques of elementary nursing is being given for a 12-month period. Upon completion of the course, the graduates will be eligible for the New York State licensing examination for practical nurses.

"OPERATION GROOM-UP" FOR TEENAGE PATIENTS—At Napa State Hospital, Cal., 30 teen-age patients have completed "Operation Groom-up," a new volunteer service for mentally ill children. Mrs. Perry Harris, a member of the Volunteer Services Committee of the San Francisco Association for Mental Health, organized and directed the three-month project. Mrs. Harris and other volunteers worked one day each week with children at the new Theo K. Miller Children's Unit of the hospital. A $200 grant from the San Francisco Foundation enabled the volunteers to buy grooming aids, clothing, and other supplies for the young patients. With the assistance of professional models, the volunteers also conducted classes in posture, exercise, and correct dieting.

NIMH APPROPRIATIONS FOR 1962– Congress voted $108,876,000 to the National Institute of Mental Health for the fiscal year 1962. Approximately $46 million of the appropriation was voted for the research grant programs, including $10 million to the Psychopharmacology Service Center for research and evaluation work in the field of drugs. The Institute's research fellowship program received $4.4 million and the training grant program, $34,856,000.

Appropriations for other activities included: the general practitioner training program, $4.8 million; clinics and related community mental health services, $6,750,000; the VA medical program $30,750,000; and community demonstration projects and training programs related to juvenile delinquency, $30 million over a three-year period.

HIGHLIGHTS

OF THE LUCKY 13th

MENTAL HOSPITAL INSTITUTE, OMAHA, NEB.

A record number of people crowded into Omaha to take part in the 13th Mental Hospital Institute, held October 16-20 at the Sheraton-Fontenelle Hotel. The official registration was 533, not counting the staff members from the APA Central Office, or the 33 psychiatric residents who came at our invitation from Nebraska, Kansas, Iowa (and even one from Pennsylvania) to attend specific meetings.

Hotel facilities were overstrained, but not the tempers of the participants who reserved their powder and shot for controversial issues raised by *Action for Mental Health*, the final report of the Joint Commission on Mental Illness and Health. Twenty workshop groups, led and recorded by carefully selected chairmen and recorders, discussed their findings and recommendations under ten headings formulated by the Program Planning Committee for the 13th MHI. These reports and the skillful summations given on the last day by Francis J. Gerty, M.D., Henry W. Brosin, M.D., and George Saslow, M.D., will form the main section of the February 1962 issue of *Mental Hospitals*. The February issue also will include reports of the simultaneous discussion groups, and the full text of the Presidential Address by Walter E. Barton, M.D., which followed the annual dinner and the presentation of the Achievement Awards and Remotivation pins.

Following are two news-stories about significant events which took place in Omaha (*for other related stories, see pages 47 and 48*):

Gift for Central Office

Mathew Ross, M.D., medical director of the APA, accepted an unusual and beautiful gift for use in the APA Central Office. The gift, a ceramic-topped coffee table, was presented by John Southworth, M.D., deputy commissioner, Division of Mental Hygiene, Indiana. It was designed and executed by patients under the direction of Irene Peacock, O.T.R., and Mrs. Lottie Franklin of the department of occupational therapy, Richmond State Hospital, Richmond, Ind. The table top, glazed in ultramarine blue and antique gold, contains 2,000 handmade tiles which required eight different processes to produce. A Benjamin Rush medallion, done in white marble chip, is in the center of the table. The entire project was completed in less than two months.

Remotivation Pins

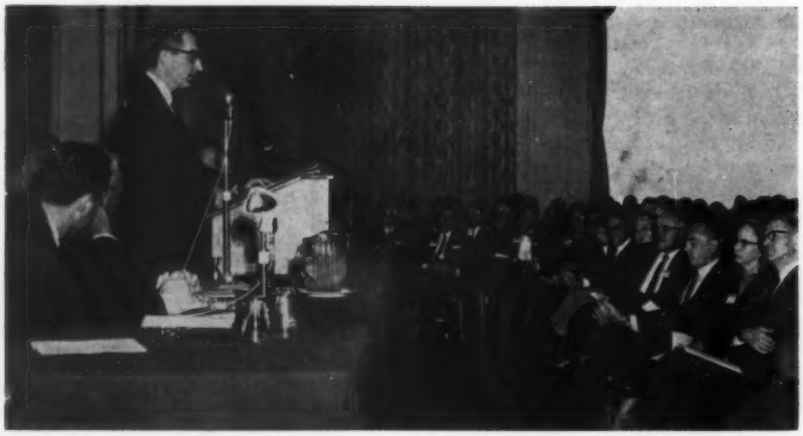
Following the presentation of the Achievement Awards at the annual dinner by the APA medical director (*see pages 4-14*), Robert S. Garber, M.D., chairman of the APA-SKF Remotivation Project, presented Remotivation Pins to six psychiatric hospital attendants: Mrs. Lois Buckley, Mrs. Elsie Frazier, and Mrs. Dan Hackley, all from Lincoln State Hospital, Lincoln, Neb.; and Mrs. Norma Elsberry, Mr. Melvin Hille, and Mr. Lawrence Jahn, all from Norfolk State Hospital, Norfolk, Neb. At the 1960 Institute, Remotivation Pins were first presented publicly in recognition of the role of psychiatric attendants in developing and expanding remotivation programs. Throughout the past year, pins have been sent to some 5,000 attendants and nurses who are participating in 136 hospital remotivation programs in 37 states. This form of recognition will be a continuing process; as new personnel complete remotivation training, they will receive pins.

When so talented a group of people as the audio-visual aids specialists at the Nebraska Psychiatric Institute take photographs of a meeting, we believe that their pictures can best illustrate some of the other highlights of the Institute. If you will turn the page, you will see some of the people who made psychiatric history in Omaha and, here and there, one or two of the people whose role was to provide the framework in which this history could be made.

Both hospital tours ended at the Nebraska Psychiatric Institute (above) where visitors saw a demonstration of closed-circuit TV. See pages 22 and 23 for description, diagrams, pictures.

Focusing on the 13th Mental Hospital Institute

FOR THE BENEFIT of those who could not attend the 13th Mental Hospital Institute in Omaha, Nebraska, MENTAL HOSPITALS is pleased to present some of the meeting's bright moments, as photographed by Reba Benschoter of the Nebraska Psychiatric Institute.



Jack R. Ewalt, M.D., Director, Joint Commission on Mental Illness and Health, opened the Institute with an address on Action for Mental Health, the final report. At the table are Program Committee members and Mathew Ross, M.D., APA Medical Director.

John J. Blasko, M.D., Program Committee, makes announcements, unfluttered by leafy background.

Paul Hoch, M.D., leads a debate about public relations problems caused by changing hospital programs. This was one of six "open" groups devoted to special areas of interest.

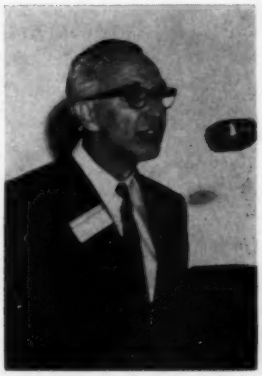
A workshop group, lead by Robert C. Hunt, M.D., discusses major mental illness. The busily writing recorder is Herman B. Snow, M.D. Trembling on the verge of speech is C. K. Bush, M.D.

Walter E. Barton, M.D. His presidential talk was on "Vanishing Americans."

These aides received Remotivation Pins from Robert S. Garber, M.D. L to R: Lawrence Jahn, Lois Buckley, Elsie Frazier, Dr. Garber, Melvin Hille, Norma Elsberry, Dan Hackley.

R. A. Cleghorn, M.D., McGill University, Academic Lecturer on psychiatric research.

Francis J. Gerty, M.D., former APA President, was the summator for nine groups.



Henry W. Brosin, M.D., emphasizes a point in his last-day summation of workshops.

George Saslow, M.D., came from Oregon to summate and comment on two days' talk.

Discussing monetary problems are Ralph Robey, Ph.D., NAM; Daniel Lieberman, M.D., Cal.; James Brindle, UAW, Detroit; Mathew Ross, M.D.; Henry Brill, M.D., N. Y.; George Bigge, Social Security Board; Irving J. Cohen, M.D., VA Central Office.

In TV sessions, patients (posed by NPI staff) sit in V-formation so that therapist (on screen) can follow facial expressions on his own monitor.

TWO-WAY TELEVISION IN GROUP THERAPY

By CECIL L. WITTSON, M.D., *Director**
D. CRAIG AFFLECK, Ph.D., *Assistant Professor of Medical Psychology**
and VAN JOHNSON, *Electronics Technician*
Nebraska Psychiatric Institute
Omaha, Nebraska

AT NEBRASKA PSYCHIATRIC INSTITUTE, we are evaluating the two-way television technique as a means of extending mental health services to areas that are remote from psychiatric centers.[1] The technique consists of a video-communication system by which two groups of people, or two persons, can see and communicate with each other at the same time. We also are investigating the effect this technique will have on group and individual therapy sessions and on psychology testing and appraisal.

Several times we have modified our procedures for television group therapy to give the therapist a clearer view of the patients' facial expressions and gestures, which are important cues for him to observe. The patients meet in a large room with their chairs arranged in V formation, facing the television screen on which the therapist appears. This arrangement gives him an unobstructed view of each member of the group and maximizes face-to-face contact between patients. The camera is placed directly above the screen on which the therapist appears, and the technician uses a fixed shot of the group in order to eliminate the distraction that would be caused if the usual television procedures were employed—i.e., moving the camera in and out for close, medium, and long shots and for different angles. The therapist, in a different room, views the group via a television screen and watches a monitor so that he can check his own position and facial expressions.

Two other monitors in a third area enable the technician to check technical problems in audio and video transmission. These monitors, one showing the therapist and the other the group, provide a clear and revealing profile of the group process that our investigators think can be effectively used to train group therapists. Particularly interesting are the clarity of the therapist's facial expressions and nonverbal communications and their effect upon the patients' responses.

Solving the Lighting Problem

We use a wired, closed-circuit television system, employing two GPL PD 150 vidicon camera chains. The initial evaluation revealed that the high intensity illumination was a major distraction to the group and to the therapist. We substituted RCA No. 7038 vidicon tubes in the cameras to provide both low-level illumination and effective video transmission.

The therapist and the group use identical receiving systems—one 21-inch GPL PD 147 monitor, with an ampex speaker-amplifier, Model A 692. Each system is mounted on a cart with the television camera fixed above the screen (see Figure I). Figure II shows a schematic outline of the entire two-way television system.

Dr. Wittson is also professor and chairman, Department of Neurology and Psychiatry, Dr. Affleck is chief psychologist, Adult Services, NPI.

[1]*This project was supported by a research grant from the National Institute of Mental Health.*

GROUP PSYCHOTHERAPY VIA TELEVISION
EQUIPMENT LAYOUT

Figure I

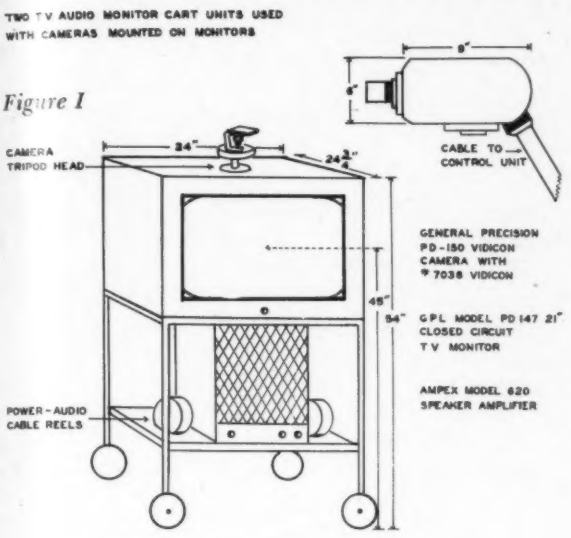
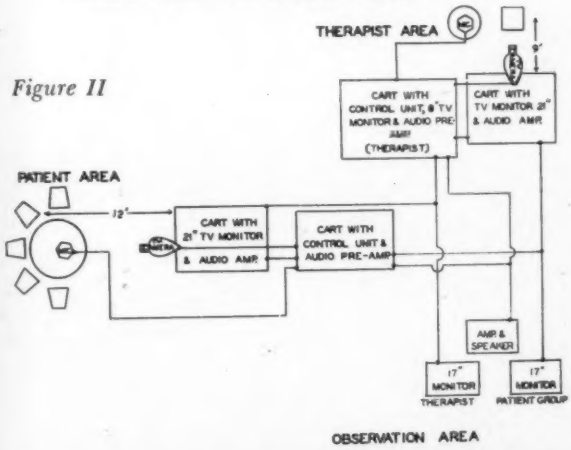


Figure II



Technician and investigator watch both screens—one to check technical problems, the other to observe group's interaction.

After we had developed the basic features of the technique, using several pilot groups, we put the system into practice on the inpatient adult service, utilizing eight therapy groups, each consisting of five or six patients. Two therapists each led four groups, two televised and two nontelevised. Each of the groups had six therapy sessions. These eight groups were part of a study to evaluate differences in patient and therapist ratings of the television sessions as contrasted with traditional group-therapy sessions.

Before the first session began, we showed all patients the technical aspects of the system and introduced them to the technician and the clinical investigator responsible for the study. We assured them that these people would be the only ones to view the discussion groups. We told patients that we were simply trying to see how the technique would work and did not mention any potential application of the procedure.

Patients Show Interest but No Concern

At their first session, most patients showed interest in the technical features of the system. Except for one or two individuals, they expressed little concern about privacy. After the first session, patients in three of the groups seldom referred to the technique itself. They began to focus their discussions on the problems typically discussed in short-term groups in this hospital—concern about hospitalization, anticipation of going home, concern about managing their particular interpersonal problems, and difficulties they encountered in their relationship with their psychiatrists or other mental health personnel.

One television group showed an atypical pattern. This group of five patients included three individuals who, prior to admission, had manifested anti-social and negativistic behavior. No relationship of trust in the therapist or of willingness to discuss problems with him emerged in this particular group. Instead, the patients utilized the television technique to strengthen their resistance, and, by whispering, managed to exclude the therapist from the discussion for some time.

We are now engaged in detailed analyses of the group and therapist ratings of televised and nontelevised group-therapy sessions. These preliminary analyses indicate that ratings are influenced substantially more by the therapist and the selection of the group members than by the television technique. It appears that the procedure is technically possible, and would be limited only by the problem of achieving clear video transmission over longer distances. New developments in microwave transmission systems, however, suggest that within the foreseeable future the cost of equipment needed to transmit over long distances will be substantially reduced. If so, two-way television group therapy may be the means for skilled mental health personnel to extend their services to persons in distant areas which have an insufficient number of therapists. •

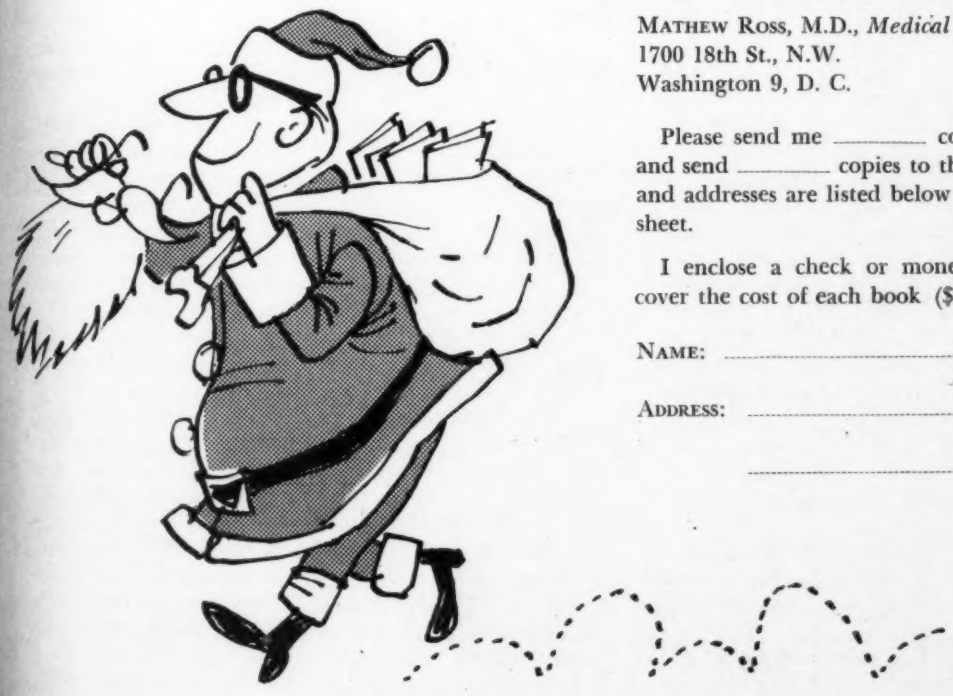
Visit the World of Dr. Whatsisname for the

For more than five years, a delightfully loveable, albeit provocatively impish character has paraded his notions before the ever-widening readership of *Mental Hospitals.* (Hospital Journal of the American Psychiatric Association.) Not a great deal is known about him beyond a rather casual conception and birth in March 1956, when he wandered in, complaining that it was not proper to call a patient by his first name. Since then his complaints and his praises about psychiatry have appeared monthly in *Mental Hospitals,* his articles and catchy sayings have been reprinted in a number of publications, and he recently starred in a motion picture entitled "Appraisal of Competency."

Now, because of numerous requests, we have assembled for the first time, "The World of Dr. Whatsisname," a collection of his pieces

Holidays . . . and . . . Bring Your Friends

in book form for your pleasure, stimulation, and ready reference. It is an enduring memento of Dr. Whatsisname, with whom agreement and disagreement are the rule and neutrality the exception. You will want a copy of this book—Dr. Whatsisname's observations, illustrated with cartoons by Ralph Robinson—for yourself. And, in all probability, you will want to share its humor and perception with many of your colleagues, and its wisdom with residents, nurses, and others with whom you are associated. We will mail the book for you, with a personalized card carrying the highly original message "Best Wishes for the Holiday Season and a Happy New Year." Just send $2.00 for each copy and a list of the people you wish them sent to. This includes postage, and, provided you act promptly and the Post Office cooperates, we guarantee delivery before Christmas.



AMERICAN PSYCHIATRIC ASSOCIATION

MATHEW ROSS, M.D., *Medical Director*
1700 18th St., N.W.
Washington 9, D. C.

Please send me _____ copies of Dr. Whatsisname and send _____ copies to the individuals whose names and addresses are listed below or attached on a separate sheet.

I enclose a check or money order for _____ to cover the cost of each book ($2.00 per copy).

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_____

A GUIDE TO SELF-APPRAISAL FOR NURSES AND AIDES

"TO HELP THE NURSE in her self-appraisal is an extremely difficult task. Complete self-appraisal would require something approaching a personal analysis. Obviously, this is not possible without individual face-to-face discussion. With this in mind, we evolved an approach that would effectively stimulate the nurse to re-examine the relevancies of her responses to the patient. We decided to use clinical material which helps to highlight the most common and typical situations to which the nurse must respond."

The "we" in the above quotation are members of the Committee on Psychiatric Nursing, Group for the Advancement of Psychiatry.* With the help of a panel of consultant nurses and aides, the Committee has prepared a new and much-needed book, *Toward Therapeutic Care,* as a guide for nursing personnel.

The first half of the book is a discussion of several psychiatric concepts which, hopefully, will lead nurses and aides to sounder understanding of patient-behavior. The second half, entitled "Clinical Applications," consists of 22 case studies that illustrate how certain attitudes, when harbored by nursing personnel, may interfere with therapeutic effectiveness. In each case-narrative, the authors have identified the nurse's reaction to the patient's behavior and have shown the relation of her response to the degree of therapeutic effectiveness.

These enlightening anecdotes and the theoretical discussion that prefaces them are worth reading in entirety—a possibility easily realized by obtaining the book from the Publications Office, GAP, 104 East 35th Street, New York 10, N. Y. (Flexible cover, $2.50; hard cover, $3.25). In the meantime, the staff of *Mental Hospitals* believes readers will appreciate the opportunity to sample the following case studies, reprinted from the book with GAP's permission.

Withdrawal from the Demanding Patient

A handsome 21-year-old Latin American student was hospitalized with the diagnosis of paranoid schizophrenia. On the day of admission the patient was dejected and withdrawn but on the second day he became excited, appeared fearful of all personnel and several times shouted out of the window, "Help me! Murder! Murder!"

On another occasion, while personnel were preparing a cold-wet-sheet-pack, he thrust his fist through the window pane. Because of his agitation, "sleep therapy" was prescribed and, since he reacted with violence to male personnel, a female nursing student was assigned to care for him during the sleep treatment. She fed, bathed, and toileted him. Within a week the patient entered into group activities. About this same time the nursing student's assignment on this ward terminated.

The patient's only visitor was his mother, a fashionable and sophisticated woman. Mother and son were exceptionally close and walked down the corridors with their arms around each other. The nursing personnel were surprised to find that on each visit the mother left comic books and lollipops in his dresser drawer.

The patient became increasingly interested in group activities; simultaneously, he gradually became more attentive to the head nurse on his ward, although he rarely spoke to anyone else. One morning while this nurse was sitting with a group of patients, the patient after staring at her for some time said, "I have committed a sin." Following a non-directive technique that she had been taught, the nurse replied, "You have committed a sin?"

"Yes," he stated, "I have eaten my mother, and that is evil."

Glowering at the nurse, he left the room. Uncertain as to what to do next, the nurse decided to remain with the other patients.

The next day the patient began to follow her about the ward. Day after day, he waited patiently and quietly outside the nursing office until she emerged. He would walk with her, staring intently, sometimes adoringly, and sometimes angrily. One afternoon as she gave him his medication, the patient smiled, looked deeply and intently into her eyes, touched her cheek, and said, "You are a good mother."

Again, the nurse restated his remark, "I am a good mother?"

"Yes."

**The chairman of the GAP Committee on Psychiatric Nursing is Benjamin Simon, M.D., of Boston, Mass.*

The nurse reported this incident to the psychiatrist who was noncommittal in his response.

From then on, the nurse never allowed herself to be alone with this patient. Instead, she tried to interest him in group activities on and off the ward. He responded by withdrawal from any further attempts to get close to the nurse, other personnel, or patients.

In this example, when the nursing student was transferred, the patient turned his interest toward the head nurse, bidding for closeness with her and probably indicating what he may have perceived as a quite difficult relationship to his mother. This was communicated to the head nurse in disguised form by fantasies. The head nurse was too uncomfortable, could not accept the patient's movement toward her or utilize it in a way useful to the patient. The patient subsequently withdrew even further from relationships with other people on the ward.

Speculations about the nature of the problems of the head nurse which served as interferences to the progress of this patient must include the impact upon the nurse of having this handsome 21-year-old male patient following her around hour after hour. In addition, there was the disturbing effect of the patient's repeated, "You are a good mother," after having said, "I have eaten my mother." This, when associated with the patient's fluctuation between adoration and anger, aroused disturbed feelings in the nurse.

The head nurse faced a different situation than did the student. She had too many other patients to look after, while the student had only this one. The nurse had insufficient supervised experience in working with this kind of problem; also she was intimidated by the destructive nature of the expression of closeness. The student did not have to face this situation since the patient was in sleep therapy.

Under the circumstances, the nurse could not respond in an appropriate helpful manner to the patient's strong demands .

She could only respond to the patient in a stereotyped, inhibited manner as evidenced by her "non-directive" approach. This was her defense against the stress of the situation; here the "non-directive" approach impaired the therapeutic relationship.

Recognizing her difficulties she went to the physician for help. He, too, was "non-directive." As her attempts to gain support from him were unavailing, she could only withdraw.

Vulnerability to Patient's Perceptiveness

Mr. P. was a financially successful, 53-year-old real estate broker who was admitted to the hospital following a two-week period of hyperactivity, during which he had slept very little, ceased to be concerned with his personal appearance, and displayed increasingly poor judgment in his business dealings.

On admission he attempted to assume control over the situation with considerable urgency and to make it clear to the nurse that he was not to be reduced to patient status. His first remark was, "I'm very interested in seeing firsthand just what you do for these people here." He then continued at length, in a confidential and convincing way, to inform the nurse that he played a prominent part in the activities of the local mental health association, and was on intimate terms with several of the hospital officials.

Contrary to the usual admission procedure, the nurse first offered to show him around the ward. Mr. P. readily agreed, and by his interested, intelligent questions and his authoritative bearing soon took command of the tour, placing the nurse in the role of guide. Within twenty minutes, he had inspected the entire ward, with special attention to the kitchen and bathrooms, had introduced himself to the majority of patients and staff, and had demonstrated how the number of chairs in the day room (with adequate reading light) could be doubled by rearranging three lamps. His speech became rapid, his body movements were accelerated, and his authoritative but polite requests became demands.

In an attempt to regain control of the situation which she now realized was out of hand, the nurse abruptly said, "You have seen enough of the ward. Come with me, and we will complete your admission. You must take a shower. I'll take your clothes and have them marked." The patient replied in a loud voice, "Young lady, you will not take my clothes, and I do not need a shower. I've got a hell of a lot to do and, from the looks of this place, so have you. Now, I'll just move one of these tables out in the hall for a desk, and I'll need that pen and paper you have there."

The patient reached out and took the pen from the nurse's pocket and jerked the clipboard of admission forms from her hand. The nurse made no effort to prevent his taking these things and, without a word, turned and rapidly walked into the nurse's station. She immediately called three male aides, informed them that the patient was excited, and that they were to complete the admission procedure. She then added, "You may have to restrain him to give him his bath. In the meanwhile, I'll call the doctor and get a seclusion order."

The nurse immediately called the resident and told him she felt the patient was becoming "just too manicky." The resident attempted to reassure her, saying he had seen the patient for forty-five minutes before, and while he might be a little hyperactive, he would rapidly adjust to the ward. He agreed, however, to see the patient.

When the resident arrived, the patient went to greet him, shook hands, and said, "Doctor, you were certainly right when you told me that we've got a long way to go on this mental health business. I've got to have more cooperation. . . ."

The doctor interjected, "Mr. P, you *must* complete the admission routine, and then I'll talk to you in my office."

The patient turned to the resident, pointedly

looking at a prominent silver capped tooth about which the doctor was unduly sensitive, and said: "All that glitters is not gold; you must be a sterling character, and I'd like to see you in *my* office."

The resident replied, "Mr. P, I'll see you only after you've done what the nurse has asked you to." He then walked into the nursing station, wrote the seclusion order, and instructed the aides to complete the admission of the patient.

The provocative behavior of the patient (his grabbing the nurse's pen and papers, etc.) does not appear to be commensurate with such an intense flight and fright reaction from the nurse—especially when this particular nurse had had considerable experience with disturbed patients. A closer look at the data, however, shows several additional sources of apprehension, some or all of which could have produced this reaction. First, the patient was successful in insidiously gaining control and completely dominating the situation. He accomplished this by capitalizing on his accurate perception of the nurse's need to accede to those in authority as well as her concern with social status. The nurse, in turn, perhaps due to these same needs, focused on the healthy, well-organized aspects of the patient's behavior, ignoring the pathological implications. Thus, the nurse relinquished her authority and thereby impaired her ability to structure the situation necessary for the patient's treatment.

The nurse, instead of protecting the patient by restricting the amount of stimulation, actually exposed him to excessive stimuli by taking him on a complete tour of the ward. By the time she perceived the patient's hyperactivity, she could no longer smoothly effect control over the patient's behavior. The patient's complete rejection of her crude and desperate attempts to set limits served to further increase her apprehension; as a result, when he jerked the pen and paper away from her she reacted as if she had been subjected to actual physical assault.

The doctor was also vulnerable to the patient's aggressive perceptiveness. The patient's cutting reference to his silver tooth and "sterling character" struck the resident, and he responded by withdrawing from the patient. By writing the seclusion order, he re-inforced the nurse's inaccurate assessment of the patient's behavior. This nurse had in the past been quite successful in caring for overactive patients. It might be helpful to view her inadequacy in the present instance.

Frequently, in nursing texts, behavioral hyperactivity is considered as an entity, and principles and procedures for patient-care do not take into consideration essential qualitative differences in hyperactivity. Excited behavior of a random, non-goal-directed type such as is often seen in schizophrenia elicits different emotional responses on the part of the nurse than the more goal-directed, more controlling behavior of the manic patient. Behavior of the latter kind, with direction and purposefulness, often arouses much more anxiety in the staff than an equal degree of disorganized hyperactivity. One explanation of this reaction lies in the fact that the diffuse non-purposeful type of over-activity is sufficiently alien to the nurse's own feelings so that there is little possibility of her identifying with this aspect of the patient. On the other hand, as in the incident above, the purposefulness and goal-directedness of the patient's over-active behavior sufficiently corresponded to feelings within the nurse so that some identification was possible, and control over her own impulses was threatened.

Frustration by Negative Response

During her first week of hospitalization, Mrs. O struggled against an underlying depressive reaction. She manifested symptomatology and behaved in a manner ostensibly designed to put some distance between herself and personnel. She protested that she really did not need to be in the hospital and was not "crazy like the other patients." After a short period in the hospital, however, Mrs. O's protests became less vehement, and she began to make tentative approaches to other patients and personnel.

When Nurse P spent one morning in shampooing and setting several patients' hair, she noticed that Mrs. O was observing her quite closely and was lingering near the doorway. It was apparent that the patient's hair needed to be shampooed, and the nurse assumed that the patient's behavior indicated a desire for a shampoo. When Nurse P completed her work on another patient, she walked over to the doorway and asked Mrs. O if she would like to have her hair set. Somehow frightened by this interaction, Mrs. O responded, "I am quite capable of doing my hair and I don't need you." Although taken aback by this response, Nurse P asked the patient if she had ever thought of cutting her hair shorter to bring out the natural wave. Mrs. O snapped, "Why should I look like the rest of the patients on this ward with their chopped-off hair? If I want it cut, I'll have it done." She then stormed down the hall back towards her room.

Nurse P stood in the doorway, feeling useless, helpless, and irritated by the turn of events. She was afraid to approach the patient on this subject again, deciding that it would not be of any use.

Nurse P enjoyed "doing something" for patients whom she felt were helpless. She derived a great deal of satisfaction from being looked upon as a "helpful nurse" and was easily frustrated when patients resisted her efforts. She had a strong wish to be needed and consequently placed herself in situations where she could advise patients and even other members of the personnel who needed assistance. Dependent patients who reached out for contact and pleaded for help in a direct way were a source of gratification to her. When Nurse P noticed that Mrs. O needed a shampoo, and was standing near the doorway, she correctly interpreted this behavior as a desire on the part of Mrs. O to have a shampoo and she fully expected a positive reaction to her question. When the

patient responded in the manner described above, the nurse was offended and felt rejected by the patient. She interpreted the response as a personal insult and failed to understand the patient's fear about being hurt in a relationship in which she allowed her dependency feelings to emerge.

Had the nurse not experienced the interaction as a personal injury, she would have been able to explore alternatives to find an area where it was possible to provide therapeutic contact for this patient. It is also quite likely that Mrs. O perceived the nurse's offer for a shampoo as something other than an attempt to make a therapeutic relationship and could not allow herself to accept the offer under such circumstances. She was frightened that she might somehow be exploited by Nurse P.

Conflict Between Professional and Personal Moral Standards

The young, very proper student walked into the day room. Stretched out on a sofa was a young male patient, openly masturbating. The student turned, walked out of the day room, and encountered a male nurse entering the day room. He asked her what was wrong as her facial expression indicated that she was upset. She said, "That nasty Mr. X is at it again, and I wish you would do something about his acting like that in the day room." The student nurse went into the office and asked the head nurse why such activity was allowed. She further stated that Mr. X should be put in his room. The entire response was inconsistent with her previous relationship with this patient.

In this situation, the student was repulsed by Mr. X's behavior. She was rejecting him as well as his activity. She had many feelings about "such things" and could not in any way accept this as part of the patient's illness. She could see that the patient was withdrawn, that he responded to voices, that he had to be encouraged in everything that he did in regard to his appearance—this was part of his illness. This she accepted, but masturbation was something else. The student had definite ideas of "right" and "wrong," and was very much concerned about moral standards. As long as the patient did whatever she thought was morally "right" she accepted him; when he did something she considered "wrong" she rejected him completely. To disapprove of the behavior and direct the patient to other types of activity was at that time out of the question because she also disapproved of the patient. Here the student was not able to use herself therapeutically because her feelings got in her way. Her own concept of "wrong behavior" resulted in her rejecting everything about the patient and left no opportunity for her to help him.

The student's conflict was in having to deal therapeutically with the patient's needs and limitations, as an expression of a whole person, while at the same time experiencing in herself considerable disapproval of the specific disturbing behavior. This nurse had previously expressed her feelings to the instructor that anything remotely concerned with sex was bad and she couldn't talk about it. In her own background, "things pertaining to sex" were not proper and they were not discussed. Therefore, she had a great deal of difficulty with problems of this type.

The nurse's reaction was not entirely inappropriate, except that she confused her feeling about sexual behavior with her judgment about the patient. The area of her problem is indicated by the fact that she was able to accept all of the psychotic activity as an indication of illness, at the same time that she rejected the patient completely because of his open masturbation. This was hinted at in the initial description of this nurse as a young and *proper* student. The inconsistency in her response to difficult aspects of the patient's behavior should be the focal point of discussion in individual supervision. •

Hospital "Kwells" a Creeping Problem

KWELL SHAMPOO HELPED solve a "creeping" problem in the adolescent female reception service at Rockland State Hospital, N.Y. Staff observation over a period of one year showed that over 14 per cent of the young girls admitted were infested with nits and lice (*Pediculus capitis*). Eleven of these children were treated with Kwell shampoo, with excellent results.

Nurses used the following treatment method: (1) hot soapy bath or shower, (2) Kwell shampoo, (3) vigorous massage from 5 to 15 minutes depending on the length and thickness of the hair, (4) rinse thoroughly and dry with a towel, (5) comb away any remaining nits, (6) re-examine patient the following day and remove her from isolation if no infestation is apparent.

One Treatment Enough

The nursing staff found that one treatment was enough. With the active pediculocide, gamma isomer of hexachlorocyclohexane, the shampoo efficiently eradicated lice and nits without unpleasant cosmetic problems or excessive use of staff time.

Although no known diseases are transmitted by *Pediculus capitis*, it can create an obvious problem in a hospital. It can be detected by examination of the hair and scalp; frequently, there are numerous infected excoriations and a moderate posterior cervical adenopathy. Patients with itching and eczematous dermatitis of the scalp and neck may also be infected.

ANNA J. MUNSTER, M.D.
HELEN BOLLMAN, R.N.
JOHN C. SAUNDERS, M.D.
Rockland State Hospital and Research Facility
Orangeburg, N.Y.

Face Lifting an Old Hospital

A Doctor and an Architect Rejuvenate a "Ghost" Hospital

By E. H. CRAWFIS, M.D., *Superintendent*
Fairhill Psychiatric Hospital
and RUDOLPH TICHY, B.S., *Architect*
Cleveland, Ohio

"IT'S SO CHEERFUL AND HOMELIKE, I don't want to go home." "I'm happy to send my mother here for treatment. . . ." "It's a wonderful place to work in!"

These comments about the recently opened Fairhill Psychiatric Hospital come regularly from patients, relatives, and staff members who appreciate the clean, spacious, and attractively decorated hospital buildings. They cannot quite believe that five years ago the same buildings were deserted, decayed with disuse, and uninhabitable.

The state of Ohio acquired this institution, valued at $1,450,000, from the Federal Government in February 1956. It was formerly known as the Marine Hospital and operated by the U. S. Public Health Service. Located on a 10-acre campus, it consisted of 13 brick buildings—one main hospital building, two nurses' residences, one building for attendants' quarters, five separate double houses, a superintendent's residence, and three service buildings for garage and storage space. All of the buildings were at least 35 years old but were structurally sound. The equipment had been removed when the hospital was deactivated and the buildings, unoccupied for three years, had deteriorated rapidly.

Reactivation Is Expensive

Our problem was to turn the institution into a receiving hospital for the intensive treatment of patients with acute and early mental illness. We assumed that, since the facility had been in operation just three years before, we could return it to operation with a quick refinishing at relatively little cost. This expectation proved untrue; the final cost came to approximately $1,750,000.

The main hospital building, which was our primary concern, consisted of four wings: A, B, C, and D. The patient wings, B and C, each contained four stories and a basement. The service wing, D, with laundry, kitchen, and dining rooms, had three stories and a basement. Wing A, with three stories and a basement, contained administrative space, a ward, and clinical areas, such as operating rooms, central supply, laboratory, X-ray department, etc.

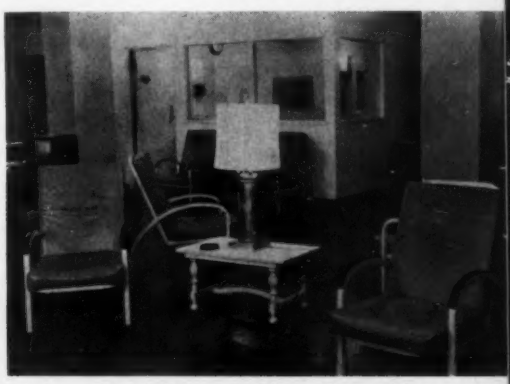
The boilers were 30 years old, hand-fired, required a special grade of coal, and were practically beyond repair. We replaced them with three new gas-fired boilers, with fuel oil standby. We found the electrical wiring was outmoded, insufficient to carry heavy loads of modern equipment, and hazardous; this necessitated putting in new conduits, new panels, new switches, and new electrical fixtures. We also had to replace the elevators with new ones.

Emergency Provisions Installed

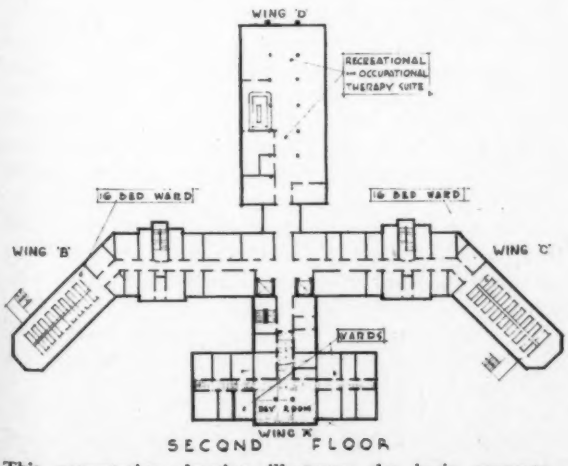
There were no provisions for emergency operating conditions, so we obtained two standby generators. One unit supplies power for key lighting-circuits; the other provides power for one elevator, heating units, and other heavy power-consuming units. The boilers are gas-fired but provided with oil burners and a ten-thousand-gallon tank for use in emergency situations. We also had to install fire escapes in the main building to provide emergency exits for patients.

Many water lines were corroded; some were almost completely closed with rust deposits, and their valves and fittings needed replacement. Lavatories, tubs, showers, etc., had to be installed in all ward areas. Heating and ventilation systems required a great deal of work; radiators, traps, valves, and fittings had

The Fairhill Psychiatric Hospital stands quietly among the trees on its 10-acre campus, bearing little resemblance inside and out to the deserted hulk of the "de-commissioned" Marine Hospital of the United States Public Health Service.



The rooms above (L to R) are sleeping cubicle, snack bar, day room looking toward the nurses' station, and (below) the lounge area in the recreation section. "Do-it-yourself" touches, with pleasing, colorful basic decor, obviates "institutional look."



This presentation drawing illustrates the basic concepts—small rooms, open design—on all four floors of the hospital.

to be replaced in order to insure reliable operation.

All of this work on the electrical, plumbing, heating, and ventilating systems meant breaking into the plaster and tearing out walls anyway, so we took the opportunity to make some improvements in the building's design to better accommodate our treatment program.

Planning for Patients

In modifying the patient areas, we planned the first floor of B and C wings as two open wards (see floor plan on page 31. On the second floor, one ward is for receiving male and female patients; the other is for disturbed patients of both sexes who require more security. We placed psychosomatic and neurological patients of both sexes on the third-floor wards which are close to the clinical area in A wing. The fourth floor is for moderately disturbed psychiatric patients. Over-all, we provided for 176 beds for patients on nine wards—eight in B and C wings, and one in A wing.

The wards on B and C wings are almost identical. Each is divided into two basic areas with an open "dormitory" area at one end and several smaller rooms —a five-bed room and two single rooms, plus rooms for toilets, baths, and, at the other end, utility and nursing stations.

Our first design innovation was to provide cubicles in the dormitory areas to give ambulatory patients more intimacy and privacy. Each one- or two-bed unit allows sufficient space for activity, for quiet reading or sitting, and for socializing with others. We accomplished this by using 6½-foot partitions to divide the area. By removing or shifting the partition wing-wall, any module can be created. Each cubicle provides adequate privacy with no sacrifice of natural lighting, ventilation, or nursing supervision. The cubicles are joined by a row of locker units, complete with desks, in which patients can store their clothes and personal belongings. The tops of the locker units support a continuous chase which houses a conduit for a pillow speaker-system, bed lights, and provisions for a nurses' call system. In addition, each bed has a built-in foot-locker. Patients tell us that our plan provides both a sense of privacy and one of participation in group living and social interaction. They frequently decorate partition dividers with get-well cards, posters, cartoons, and drawings.

We used dividers to provide privacy in the multi-bed rooms at the other end of the ward, and put separate shower stalls and dressing units into the shower room.

The end section of the dormitory and one of the rooms were set aside as lounge areas and dayrooms. The area near the cubicles is reserved for quiet activities, so as not to disturb patients in bed, and the other room is used for more active pursuits.

Two of the single rooms are used as offices, one for the ward psychiatrist and the other as an examining and treatment room. The other single room is a seclusion room with psychiatric screens on the windows, radiators located near the ceiling, and light switches outside the door. In some of the wards, an additional room serves as an office for a psychologist or social worker.

Originally, the ward on the second floor of A wing consisted of many small patient-rooms with no dayroom space. We added a nurses' station, toilets, showers, and utility rooms.

We do not use a central dining room for two reasons: to insure separation of patients by diagnosis and to keep them in small family-type units. Instead, each ward has a small dining room furnished with tables, chairs, and kitchenette unit. Meals are prepared in the central kitchen and sent in combination heated-refrigerated carts to each ward dining area at mealtime. For snacks, especially during social and visiting hours, we use kitchenette units, each containing a small refrigerator, a range-top unit, sink, base and wall cabinets, and an ice-bin. In practice, these small rooms also provide a suitable environment for visiting areas or dayrooms.

Color Psychology Useful

Painting and redecorating the interior of the building was the most provocative and challenging phase of the project. Working within the confines of an existing structure meant that we had to do the best we could to establish the kind of therapeutic environment we wanted, even though the ratios of wall-to-window areas, exposures of various rooms, ceiling heights as related to volume of rooms, etc., were already established. Thus the proper selection of colors became more important than the architecture in establishing the building's character.

We collaborated with a color consultant to develop a system of colors and furnishings which would present an effective environment not only for patients but also for staff and visitors. We used subdued colors for highly nervous or agitated patients, and brighter, more stimulating colors for less active patients. These basic colors were modified according to the orientation and exposure of the various rooms and spaces. Some 110 paint colors, textures, and hues were used throughout the structure, complemented by various floor finishes and colors, items of furniture (beds, wardrobes, desks, tables, and chairs), carpets, and draperies. Yet, when one walks through the corridors and rooms of the completed project, he does not notice the kaleidoscopic use of color.

In addition to painting the wards, we added acoustical tile and psychiatric screens.

The easthetic result complements, defines, and delineates the various departments within an over-all pattern of complete unity, producing an atmosphere of well-being and comfort that influences patients, staff, and visitors.

There were very few significant design changes in the clinical area, and structural changes were limited to those necessary to accommodate new equipment.

The same was true of the laundry area. However, the kitchen, as well as the staff dining room, had to be redesigned.

There were three departments for which no space had been provided in the original layout. These were recreation therapy, occupational therapy, and nursing education.

The recreation therapy area, including a snack bar, was a major design problem. This wing originally consisted of a central corridor flanked by dining rooms, separated as required by military protocol. To achieve maximum utilization, light, and ventilation, we removed practically all interior partitions, which left a large open room with windows on three sides. By using folding doors in various groupings, we developed an area that gives multiple and flexible usage. The room is available for varied activities and small or large group participation. One section has permanent booths and tables and chairs; the remainder, being quite flexible, can be used for card playing, ping pong, occupational therapy, large meetings, movies, lectures, and religious services. Only minor changes and redecorating were needed to furnish an occupational therapy area and space for the employees' locker rooms and lounge area.

Nursing education was assigned to a building of frame construction, previously used for physical therapy. The existing trussed ceiling space was insulated to insure summer comfort, and interior ceiling areas were surfaced with acoustical tile for sound control. A mock-up of a ward cubicle unit was installed to facilitate teaching procedures. Folding doors assist in segregating space for small group participation as well as for visual education needs.

Outpatient Department Completed Early

We originally planned to locate the outpatient department in the basement of wing B, but, in providing for the various other needs of the program, we ran out of space. Instead, we converted a former nurses' dormitory to this use. This building was easy to renovate and was located conveniently to parking areas and the administrative, medical, and clinical facilities of the main building. Traffic between the two structures worked out well for both staff and patients. Necessary offices, examination rooms, conference rooms, and other related facilities were easily provided by minor demolition and construction. The bulk of the work consisted of repainting, new flooring, acoustical work, and new lighting fixtures. We were happy to have the facilities of the detached outpatient department finished and in operation some months before the completion of the main building. This permitted us to treat limited numbers of patients and to organize and train the newly recruited staff.

The original flooring, in most areas, perplexed us. The floors in the main building were battleship linoleum with painted cement borders and bases. Some areas (kitchen, toilets, and the like) were surfaced with ceramic mosaic and a few had asphalt tile applied over the linoleum and cement borders. The surgical suite did not have conductive flooring. Ideally, all the floors within the main building should have been replaced or resurfaced, but the budget limited us to making only the necessary improvements.

We installed a new quarry tile floor and base in the kitchen area. Our experience showed that terrazzo-type flooring with cupric-oxide additive is better for general use and maintenance in such areas. A vinyl conductive floor was used in surgery and associated areas. Laboratories, special offices, etc., were floored with vinyl asbestos. The original linoleum in the majority of the remaining rooms and areas such as dayrooms, wards, bedrooms, corridors, etc., was cleaned and buffed. The cement borders and bases were painted. When more money is available, vinyl asbestos or rubber-tile flooring and resilient bases will go into these areas.

In addition, all the buildings were cleaned by sand blasting, spot painted, caulked, damp-proofed, and trim-painted. The administrative offices required relatively minor changes and decoration.

Upon the completion of this project in March 1959, Ohio had a sorely needed, complete facility for less than one-half the cost of a comparable new unit. More important, the hospital occupies an ideal site which would be almost impossible to acquire for a new hospital. •

A Mail-order Drug Program for Discharged Patients*

By W. L. JAQUITH, M.D., *Director*
Mississippi State Hospital
Whitfield, Mississippi

WHAT HAPPENED TO ONE OF THE FIRST PATIENTS we discharged on a new psychiatric drug strikingly reminded us that many patients' families face a disturbing dilemma today. How can they obtain drugs that are so necessary for a patient's well-being without having the family budget give under the strain?

The particular patient who brought this problem home to us had been in our hospital for several years. She had not responded to any type of therapy for a prolonged period. Then, a new tranquilizer wrought a complete change in her condition and a fine remission of her mental symptoms. We notified her family that she would be able to leave the hospital. They were overjoyed and immediately came to take her home. We gave the patient's husband a prescription so that he could procure the drug outside of the hospital.

High Cost of Tranquility

Within a few hours after the patient left, her husband returned to the hospital almost in tears. He had gone to a local pharmacy to have the prescription filled and had been charged more than $50 for a month's supply of the drug his wife needed. This man earned only $50 a week with which he had to support himself, his wife, and four children. He said he could manage to purchase the drug once but if he had to continue to do so at the sacrifice of a week's pay every month, he could not afford to keep his wife out of the hospital.

This patient's plight startled us and made us think. We had believed that the new drugs would make it possible for us to release many patients, but how could we if drug prices were prohibitive and patients could not continue on medication outside the hospital? In many cases if medication were not continued, the patients would relapse and return to the hospital.

Postman to the Rescue

The hospital's director and pharmacist decided that, since we bought these drugs in tremendous volume at marked reductions over retail prices, we could institute a mail-order service for discharged patients. The hospital staff agreed that it would be a good practice to allow patients on leave to buy drugs from the hospital at cost, plus postage and sales tax. This could mean the difference between the patient functioning usefully in the community or returning to the hospital.

We began our mail-order program late in 1955. Because of it, we are now able to distribute approximately 9,000 drug orders a year to some 1,400 patients on leave or discharge status.

When a patient is ready for release, the staff psychiatrist in charge of his case gives him a form letter that explains the availability of the drugs and how they may be ordered. On the letter, the psychiatrist writes the name of the medication, instructions for taking it, and its cost. Before a patient leaves the hospital, he purchases his first drug order in the hospital pharmacy. When he is at home and needs more drugs, he orders them from the hospital according to the instructions contained in the form letter.

**Adapted from an article first published in Alabama Mental Health, March 1961.*

A clerk maintains a record of every patient and the amount of drugs sent each time an order is filled. The clerk, hospital director, pharmacist, and staff physicians check the record frequently to make sure that a patient is taking only the prescribed amount of drugs and is not permitting others to take them.

Careful Checking Necessary

If there is evidence that a patient is taking the drug to excess or if we find that he is channeling it into other outlets, we write to him about it. We ask a member of his family to contact his personal physician to ascertain whether or not the patient is taking the prescribed amount of drugs. We immediately withdraw a patient's drug privileges if we discover that he is permitting someone else to use the drugs or is reselling them.

Many patients request our drug department to send them various types of medications. But we sell them only tranquilizers, energizers, or anticonvulsant drugs used for epilepsy, along with such drugs as Cogentin which alleviates some of the side effects of the phenothiazine derivatives. We do not sell any other type of drug.

We make it an absolute rule never to give drugs free of charge to released patients. When, because of limited financial resources, they are unable to buy drugs, a mental health association, welfare department, civic club, or church group generally provides funds for the drugs.

At first we were criticized for helping to "socialize the drug industry." A legislative committee asked us to inform them about our program. In doing so, we found that in 1955 an average discharged patient's family paid $72 to buy drugs from the hospital. Most of these families said they could not have afforded to buy the drugs at retail prices. During this same year, it cost the state's taxpayers approximately $775 to keep a mentally ill patient in the hospital. We asked the committee: should the state and its taxpayers maintain patients in the hospital at $775 each per year or make it possible for them to remain outside the hospital, contribute to the community and to state income, and pay the $72 a year themselves? We ceased to be criticized after submitting this lesson in simple arithmetic.

During 1960, the pharmacist sold $70,175.74 worth of drugs by mail. He filled 8,983 drug orders for 1,383 patients. The average cost per patient was $50.12—a marked reduction from the $72 in 1955.

We believe this program has greatly assisted us in reducing our readmission rate. We are certain that if we had not instituted our drug program, numbers of our patients could not have afforded to remain out of the hospital. As it is, this program has helped many patients to remain in remission who would not have done so otherwise. •

INBRIEF Niamid, brand of nialamide, is 1-(2-[benzylcarbamyl] ethyl)-2-isonicotinylhydrazine, a well tolerated antidepressant that may correct or relieve depression on once-a-day dosage. **Indications:** Depressive syndromes of varying degrees of severity may be responsive to Niamid including: involutional melancholia, postpartum depression, depressed phase of manic-depressive reaction, senile depression, reactive depression, schizophrenic reaction with depressive component, psychoneurotic depression. In neurotic or psychotic patients, Niamid may normalize or favorably modify aberrant or excessive reactions and symptoms of depression such as: phobias, guilt feelings, dejection, feeling of inadequacy, discouragement, worry, uneasiness, distrustfulness, hypochondriacal and nihilistic ideas, difficulty in concentration, insomnia, loss of energy or drive, indecision, hopelessness, helplessness, decreased functional activity, emotional and physical fatigue, irritableness, inability to rest or relax, sadness, anorexia and weight loss, and withdrawal from society. **In the withdrawn patient,** Niamid may elevate the mood so that there is increased activity, increased awareness and interest in surroundings, and increased participation in group activities. Appetite may be increased and there may be decreased fatigability. Lack of clinical response to other antidepressant therapy does not preclude a favorable response to Niamid. Relief of depression may also be evidenced by elimination or reduction of the need for somatic therapy, such as electroshock. **In patients suffering from depression associated with chronic illness,** Niamid may improve mental outlook, reduce the impact of pain, decrease the amounts of narcotics or analgesics needed, and improve appetite and well-being. **In patients with angina pectoris,** Niamid has been found to be a useful adjunct to management through reduction in frequency of attacks and pain. **Dosage:** Starting dosage is 75 to 100 mg. on a once-a-day or divided daily basis. This may subsequently be adjusted depending upon the tolerance and response. Responses to Niamid are not usually rapid, and revisions of dose should be withheld until at least a few days have elapsed at each level. Increments or decrements of 12½-25 mg. are generally sufficient. A daily dosage of 200 mg. is the maximum recommended for routine use. (As much as 450 mg. daily has been used in some patients.) **Side Effects:** Niamid, in clinical use, has been characterized by a significant lack of toxicity. It is generally well tolerated. Nervousness, restlessness, insomnia, hypomania, or mania, sometimes occur. Occasional headache, weakness, lethargy, vertigo, dryness of the mouth, blurred vision, increased perspiration, constipation, mild skin rash, mild leukopenia, and epigastric distress may be obviated or modified by reductions in dose. Effects due to monoamine oxidase inhibition persist for a substantial period following discontinuation of the drug. **Precautions and Contraindications:** Hepatic toxicity has not been reported in extensive clinical studies. However, if previous or concurrent liver disease is suspected, the possibility of hepatic reactions and liver function studies should be considered. The suicidal patient is always in danger, and great care must be exercised to maintain all security precautions. The apathetic patient may obtain sufficient energy to harm himself before his depression has been fully alleviated. Niamid may potentiate sedatives, narcotics, hypnotics, analgesics, muscle relaxants, sympathomimetic agents, thiazide compounds and stimulants, including alcohol. Caution should be exercised when rauwolfia compounds and Niamid are administered simultaneously. Rare instances have been reported of reactions (including atropine-like effects, and muscular rigidity) occurring when imipramine was administered during or shortly after treatment with certain other drugs that inhibit monoamine oxidase. **In Cardiology:** The central effects of Niamid may encourage hyperactivity and the patient should be closely observed for any such manifestation. Orthostatic hypotension or hypertensive episodes occur in a few individuals and cardiac patients should be carefully selected and closely supervised. **In Epilepsy:** Although in some patients therapeutic benefits have been achieved with Niamid, in others the disease has been aggravated. Care should be exercised in the concomitant use of imipramine, since such treatment with monoamine oxidase inhibitors has been reported to aggravate the grand mal seizures. **In Tuberculosis:** Existing data do not indicate whether resistance of M. tuberculosis to isoniazid may be induced with Niamid therapy; nevertheless, it should be withheld in the depressed patient with coexisting tuberculosis who may need isoniazid. As with all therapeutic agents excreted in part via the kidney, due caution in adjusting dosage in patients with impaired renal function should be observed. **Supplied:** *Niamid (Nialamide) Tablets, 25 mg.: 100's — pink, scored tablets; 100 mg.: 100's — orange, scored tablets.*

More detailed professional information available on request.

particularly useful for depressed office patients because Niamid provides:

Remission of depression—smoothly, gradually, without "jarring." Parker[1] reports that although Niamid is a slow-starting drug it produces a smoother effect than certain other antidepressants—those causing exaggerated CNS stimulant effects such as jitteriness, pressure of activity. "This is an advantage of nialamide [NIAMID] because such side effects frighten depressed patients and retard their improvement."

Notably low incidence of serious complications or side effects. After laboratory tests of patients on Niamid therapy, Ayd et al.[2] found: "Thus, in contrast to other antidepressants, nialamide [NIAMID] has not caused anemia or any disturbance in renal or hepatic function."

Convenience of once-a-day dosage.

1. Parker, S.: Dis. Nerv. System 20:2, Dec., 1959.
2. Ayd, F. J., Jr., et al.: Dis. Nerv. System 20 (Suppl.):34, Aug., 1959.

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THE POSITIVE SIDE *of Institutionalization*

By WANDA PARTRIDGE, *Clinical Social Worker*
Neuropsychiatric Hospital
Veterans Administration Center
Los Angeles, California

ON ONE OF OUR 210-BED WARDS, schizophrenic patients who have been hospitalized from five to 20 years have recently shown remarkable improvement to the point of being "recovered" from their illness. However, these same patients were trapped in the very process of stabilization that had produced their recovery. Having emerged from the acute stage of their psychoses, they talked, acted, and thought sensibly but had become routinized, dependent, and fearful of the outside world. They had become accustomed to the hospital and looked upon it as their home, counting on ward personnel for care and protection.

During the past four years, as the social worker on this ward, I have been trying various methods to help these patients to "try outside"; I have searched for a more meaningful way of preparing them and their families to live together by using the positive factors of institutionalization that have contributed to the patients' improvement.

A predominating reason for hospitalizing a schizophrenic is that "things outside get to be too much" and he becomes tense, anxious, and insecure. If the strain persists, tension and insecurity increase, and the individual protectively closes himself to the world around him. Usually, it is at this point that he is doing and saying strange things; hopefully, someone helps him to get into a hospital.

In the hospital, we try to reverse the process that made him sick. Initially, we take over for him, nurture and protect him. He is safe from outside pressures. Gradually, we establish a daily routine for him; he begins to feel secure, slowly "comes out of the fog," starts to take a look around him, and eventually is compatible with the safe world inside the hospital.

How long it takes a patient to make this much of a comeback depends on his previous experiences, his own inner resources, and what is expected of him *now*. If we expect too much, he can go in and out of his own private fog until we figure out his limitations and adjust our expectations. When we do, it is possible for him to feel safe enough to "stay with us." At this point in his recovery, we frequently refer to him as "institutionalized," implying hopelessness—poor prognosis for leaving.

Prognostic Paradox?

This attitude condemns the very program of treatment that provided the means for recovery. I have never been able to accept it. I believe that the process that has promoted healing contains positive elements that can be used to give a patient sufficient security to try outside. I think I have found the positives.

I must admit that, for a long time, the institutionalized patients in my groups have been trying to tell me what those positive elements are. They are simple, practical elements—so simple, perhaps, that I could not get their message. The positives have to do with such statements as: "I like *here*." "*Here* is good." "I need *here*."

When I asked members of the group to help me to understand what was good about "here," they told me in essence: "Well, you see, we know what is expected of us here. We know where we stand, so we feel safe. It's different outside. We don't know what will be expected of us." They listed items of their daily routine—meals three times a day, bathing and shaving three times a week, going to bed and getting up at set times, changing clothes periodically and maintaining a good appearance, taking medicines, making beds, helping with ward cleanup, and so forth. Some statements were especially revealing: "We let people help us." "We have a daily detail." "We must do these things—you (the hospital) expect it."

I jotted the comments down and read them back to the group. All of the patients nodded in agreement. Then I asked, "Are you trying to tell me that if these

things were all that would be expected of you outside, you could then try to live outside?"

There was a unanimous, "Yes, we could try."

That was the birth of a practical method of preparing a patient and his family for his departure from the hospital. I believe it helps if a patient has been able to realize that he is not being released to do as he pleases, but that certain things will be expected of him and that *he has a responsibility to himself* in living up to them. I define our expectations as "just what we expect of you here on ward 206—no more but no less."

I ask a patient to tell me precisely what we expect of him; we go over the list point by point. I explain that when he is sure that he can do these things at home, he will be ready to try outside. I let him know that he will have a chance to try out our expectations during his brief home visits and that his family will help him. Within this firm, realistic approach the patient can test limits, express feelings about leaving, and eventually reach the point of wanting to try.

Signals of Readiness

The patient is ready for a brief pass to go home when he has grasped what is expected of him and has shifted from rebellion against structured limits to a desire to really try to live within them. Such expressions as, "I've got it," or "I'm ready; I can do these things," are not uncommon signals.

Before a patient receives his first pass, I talk with his family about what they can and must expect of him; for instance, helping him to learn how to operate bath and shower fixtures, finding useful chores he can do each day, or helping him become accustomed to the usual family routine for meals and sleep. The passes are not granted until the family members understand their part in helping.

After each pass, I talk with the patient and family to see how matters are progressing. For example, when Joe came to see me after his first pass, he had checked off all of the things he was supposed to do except, "Help around the house and yard." "I couldn't do it," he said. "I didn't know what to do or where to find things." In a subsequent joint interview with Joe and his family, we were able to find some things that Joe *could* do.

Then there was Bill who couldn't shave because he had no shaving equipment, and Harvey who was "all shook up" when he had to sleep in his "skivvies" because he had no pajamas. These represent small but important practical things that the patient, family, and hospital assumed would take care of themselves.

Then, there are the problems of driving cars and working. In the world of "normal" people, adults do these things as a matter of course. But can Joe, who has been "out of this world," step out of "here" and work? And can Bill face the hazards of steering a car through a busy city street? Bill told me about driving the family car: "My dad said, 'Just get behind the wheel, son,' and so I did."

"Well, how did it go?" I asked.

"There was too much to watch out for. Things were moving too fast. I was afraid I would have an accident and I could feel myself start to shake."

So Joe and Bill and their families must realize that driving cars and working are too much for the patients *now* and that if Joe and Bill accomplish their listed expectations they will be making sufficient progress. This will give them their start. Patients seem ready to leave and families to have them, when they have mastered the things on the list, can do them consistently, and show some initiative in finding new things to do in their homes.

Leon was one of the first patients to receive a pass after having had this kind of preparation. He was a schizophrenic veteran who had not set foot out of the hospital in 14 years. He had no income, and his family was on relief—about a 500 to 1 shot, I would say, for successful adjustment outside the hospital. After a month's leave, he came in for his medical check-up. As long as I live I'll never forget the sight of this big, six-foot hulk of a fellow as he came down the hall, broadcasting, "It works, Miss Partridge! It works! I can make it!"

I said I wanted to hear all about it, and Leon told me, "I did just what you said to do. When I make my bed, my mother says, 'Leon, how did you learn to make such a beautiful bed?' and I say, they taught me at the hospital. When I shave and change my clothes, my mother says, 'Leon, how did you learn to dress so neat?' and I say, they taught me at the hospital. When I mop and wax the kitchen, my mother says, 'Leon, where did you learn to do that?' and I say, I learned it at the hospital." He ended with a triumphant statement, "Oh, Miss Partridge, my mother thinks I'm wonderful."

"And so do I," I replied.

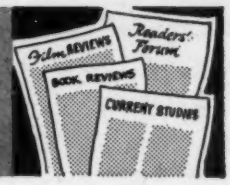
Leon has been outside now for a year and for the past three months has been working in a sheltered workshop.

I have no mass of statistics to present in support of the method I have described, but before 1958—the year in which I initiated this way of preparing patients for leave—the leave rate in our ward was only two a year. During the following year, 30 patients left on trial visits. Six of them have returned. Our ward's current return rate of one in five compares favorably with the return rate for the entire hospital—one in three.

I believe that this method works because:

1) It defines our expectations, and human beings, sick or well, need to know what is expected of them.
2) It sets limits that are within the patient's capabilities, and he can feel useful, adequate, and successful.
3) It provides a structure for testing limits.
4) It helps the patient to take responsibility for himself and emphasizes his stake in the future.
5) It provides a structure for extending hospital authority into the home.
6) It transplants a meaningful part of "here" (the hospital) to "there" (the home). The patient takes something with him.
7) It sanctions parental control, uses it in a positive way, and thus, minimizes it.

Reviews & Commentary



FILM REVIEWS

Editor's note: *Instead of the usual film reviews, this month's column features a half-hour play written for performance by local professionals or amateurs. Its theme, that rehabilitation of a human being can not be completed by a professional expert and a hospital, makes it especially pertinent to mental hospital personnel engaged in preparing patients for separation from the hospital.*

THE PICNIC BASKET (a one-act play, 30 minutes, produced for the Office of Vocational Rehabilitation, U. S. Department of Health, Education, and Welfare, by PLAYS FOR LIVING, a division of Family Service Association of America.)

Recent films have treated the problems of the former mental patient with sensitivity and have illustrated the work of various professional persons involved in helping him. Now we have a *play,* commissioned by the Office of Vocational Rehabilitation, which emphasizes the importance of support from the ex-patient's co-workers—without neglecting the important role of the rehabilitation counselor.

In "The Picnic Basket," Russell Cook, a former mental patient who is in his thirties, comes to work in the bill-posting department of an office. It is made clear that this new job is the test of whether or not he can keep himself on the road back. Fear of discovery that he has been in a mental hospital makes him slow in his work and keeps him from enjoying friendly relations with fellow workers. Stanley, one of the other men in his office, invites Russ to a beach party with some girls. After talking things over with his rehabilitation counselor, Russ accepts — despite some qualms — and, as a contribution to the outing, produces a picnic basket which he made himself. Another employee, Max, who has been suspicious of Russ and from the start has nagged him for being slow, recognizes the basket as the kind made in OT at the state hospital.

Max demands that Stanley, the shop steward, ask the boss for Russ's dismissal on the grounds that the former patient is likely to "go berserk." Stanley, a reasonable man who wants to do the right thing, asks Max for time to think, but hotheaded Max deliberately taunts Russ about being a former mental patient and urges him to fight. Instead, Russ quietly stands up to Max in a strong, dignified way that commands Stanley's respect. Stanley tells Russ that he is certain now that Russ was not a patient since he didn't "flip" at Max's accusation. But Russ, in a very effective scene, explains all about his hospitalization and subsequent struggle to stay well. At this crucial moment, Stanley decides to stick by Russ. The picnic will be held as planned.

Neatly interwoven with the office scenes are a number of sequences in which Russ discusses these problems with his rehabilita-

"Yes, I heard the silly ridiculous rumor we're cancelling all our orders with your firm. I started it."

"Fimble here has what he thinks is a foolproof commitment-admittance form."

tion counselor, who supports him. The sequences also supply the audience with additional information about the way in which a counselor works. The point is clearly made, however, that more people like Stanley are needed to give a helping hand where it is needed most—on the spot.

"The Picnic Basket" was written by Nora Stirling, well-known for her many plays on family living. She is also the author (with Nina Ridenour, Ph.D.) of "My Name is Legion," a dramatization of the life and work of Clifford Beers which successfully toured the United States some years ago under the auspices of the National Association for Mental Health. Miss Stirling's gift for pungent, realistic dialogue makes her characters much more than cardboard symbols; the audience quickly becomes emotionally involved in the problem presented on the stage. Like her other plays, "The Picnic Basket" is intended to stimulate discussion. A guide for discussion leaders has been prepared by Dr. Salvatore DiMichael, Regional Representative, Reg. II, OVR.

This play is ideal for amateur production because it requires no sets and the script includes full production details. Public information officers in state hospitals might well consider presenting it before community groups, especially potential employers of former patients. Performances before the general public would be appropriate for an observance of Mental Health Week.

Within a 50-mile radius of New York City, performances of this play are restricted to the professional casts of PLAYS FOR LIVING. For information about these performances, which are given for a nominal charge, write to PLAYS FOR LIVING, Family Service Association of America, 44 East 23rd Street, New York 10, N. Y. Outside the 50-mile radius, "The Picnic Basket" may be performed by any group. Scripts may be obtained in limited quantities without charge by writing to the Office of Vocational Rehabilitation, U. S. Department of Health, Education, and Welfare, Washington 25, D. C.

OVR rates a pat on the back for its first venture "on the boards." The Picnic Basket's moving and dramatic story should help many people to think more clearly about their feelings toward the mentally ill. Hopefully, the play will uncover more people who, like Stanley, will help the former mental patient to make his way on the long, hard road back.

JACK NEHER
Mental Health Materials Center

BOOK REVIEWS

PROBLEMS OF ESTIMATING CHANGES IN FREQUENCY OF MENTAL DISORDERS, REPORT NO. 50—Committee on

Preventive Psychiatry, New York, Group for the Advancement of Psychiatry, 1961, 54 pages, 75¢.

Since prevention of disease is the ultimate aim of the medical profession, the effectiveness of its efforts must ultimately be measured by changes in the frequency of disease. The GAP Committee on Preventive Psychiatry undertook a study of theoretical and methodological problems involved in making valid estimates of trends in the frequency of psychiatric illness and surveyed changes in the frequency of 11 disorders—conversion hysteria, cretinism, syphilitic psychoses, psychoses of the aged, psychoses associated with pellagra, deliria with pneumonia, postencephalitic encephalopathy, bromide psychosis, neurocirculatory asthenia, and psychoneurosis with diffuse anxiety. (Schizophrenia was not studied.)

Survey procedures included review of the literature of the past 50 years, study of available statistics, and a questionnaire directed to 15 senior psychiatrists who had practiced in one locale for two or three decades. The survey's results indicated a need for teams of psychiatrists, epidemiologists, and biostatisticians to carry out repeated studies of specified sample populations at regular time intervals. Focus on the application of epidemiological methods to mental illness highlights a neglected area of psychiatry which offers promise in attaining better understanding of the etiology of various disorders.

LUCY OZARIN, M.D.
Kansas City, Mo.

READERS' FORUM

Defense for OT in the U. S.

Since I am an occupational therapist at Letchworth Village, Thiells, N. Y., "Work Therapy in the Soviet Union" in the August 1961 issue of *Mental Hospitals* caught my eye. The third paragraph made my blood pressure go up.

"Work therapy differs markedly from conventional types of occupational therapy. It is not a 'make work' program; there is no aimless tinkering — no feeble attempts at ceramics or fingerpainting, no indulgent or condescending attitude toward what is being done or toward the end-product. . . ." It follows that this comparison is a superficial attempt to indicate what occupational therapy is.

In order to prevent further misconception, may I suggest that the author inform himself of what occupational therapy is. He would find that occupational therapy is used in the treatment of limitless kinds of individuals with their limited numbers of diagnoses. Before making such a comparison there should be insight into the how and why of using occupational therapy. The needs of all these patients can-

not be to make saleable end-products.

It is unrealistic to allow "technical experts" to set standards for psychiatric and/or neurotic patients. These standards are not the measurement of recovery. Meeting these standards may be concomitant with harm to the patient.

In spite of the "comparison" between work therapy and occupational therapy, this article essentially describes occupational therapy in a sheltered workshop in our country with the occupational therapist working under the close supervision of the psychiatrist.

The implication made by the comparison is that perhaps our psychiatrists need to give more supervision and guidance to our occupational therapists as adjunctive therapists before our program generally becomes a "make work" one.

ELSIE R. MCKIERNAN, OTR

CURRENT STUDIES

This column lists investigations of interest to mental hospital personnel. Authors have agreed to make copies of their papers available. Requests should be sent to them directly, with 25¢ for postage and handling.

AN ANALYSIS OF RECENT FIRST ADMISSIONS TO WYOMING STATE HOSPITAL

A research consultant to Wyoming State Hospital made a study of first admissions over a six-month period at the beginning of a new administration at the hospital. The new administration transferred emphasis from custodial care to prompt diagnosis and early treatment. The consultant conducted a similar study one year later. A comparison of the statistics shows that definite changes in admission patterns followed the change in treatment philosophy. Copies are available from William N. Karn, Jr., M.D., Superintendent, Wyoming State Hospital, Evanston, Wyo.

SURVEY OF THE PARENT VOLUNTEERS IN INSTITUTIONS FOR THE RETARDED

The coordinator of state volunteer services in Minnesota distributed a questionnaire throughout the country to ascertain the extent to which state schools and hospitals for retarded children involve the children's parents or relatives in volunteer service programs. In addition, the coordinator asked the institutions using parent volunteers to indicate the ways in which such volunteers are utilized and if their services are satisfactory. Copies of the complete study are available from Mrs. Miriam Karlins, Director, Medical Division, Information and Volunteer Services, Minnesota Division of Public Welfare, St. Paul 1, Minn.

Admin. Abstracts

PRODUCT NEWS

Anti-scald Shower Valve

The Tempera Valve, a pressure balancing line valve, maintains a constant selected water temperature. The 3 7/8" by 3 1/8" automatic valve is suitable for

shower and other water outlets. Installation is simple and inexpensive in both new construction and in existing structures. Guaranteed for lifetime of original purchaser. Tempera Corporation, 4035 No. Interstate Ave., Portland 17, Ore., will supply further information.

"Spray-Buff" Floor Machine Attachment

The "Spray-Buff" attachment which mounts on buffing-machine handles, permits the operator to spray a wax-water

or resinous-water solution on floor areas while buffing. The floor finish can be quickly restored, and scuff marks removed while the machine is in motion. Price: $16.50. For further information contact local Multi-Clean distributors or write Multi-Clean Products, Inc., St. Paul 16, Minn.

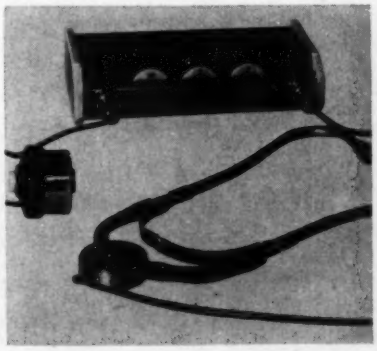
"Pfsst" Cleanser Bottle

A new spray bottle manufactured by Airkem, Inc., has been developed to assist maintenance personnel in cleaning chores. Made of nonbreakable plastic, "Pfsst" holds six ounces of Airkem's 3-in-1 detergent, disinfectant-odor counteractant, which cleans stains from doors,

walls, tables, benches, and surfaces that require spot cleaning. For a free sample, write to Airkem, Inc., 241 E. 44th St., New York 17, N. Y.

Electronic Stethescope

An electronic stethescope that amplifies 100 times better than standard acousti-



cal instruments, permits the user to "tune" for the exact tone he wants to hear. An auxiliary output allows an additional headset, external sound system, or recording instruments to be connected. Price: $146.50, complete with batteries and leather carrying case; guaranteed one year. Information available from manufacturer, Calhear Instrument Co., 412 W. Sixth St., Los Angeles 14, Cal.

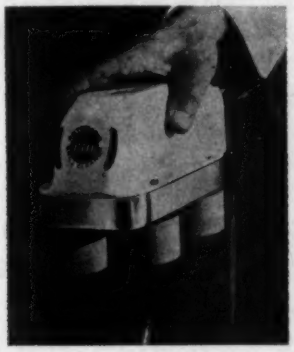
"Painless" Hypodermic Needle

A new, disposable, inexpensive hypodermic needle has been designed in type

304 stainless steel. The subjects inoculated during preliminary testing of the needle showed amazingly little pain reaction. Samples are available from the manufacturer, Heinicke Instruments Co., 2035 Harding St., Hollywood, Fla.

Grill-cleaning Appliance

The Roto-Magic Grill Cleaner, powered by a self-cooling motor with nylon gears and oilless bearings, cleans commercial-



type grills by means of four counter-rotating abrasive wheels. The new appliance, designed to clean grills at cooking temperatures, leaves no ridges or hollows to trap grease and smoothes out bumpy or hollowed-out spots. Manufactured by Rotomagic Corporation, 818 Butterworth, S. W., Grand Rapids, Mich.

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for grand mal and psychomotor seizures: PHELANTIN® Kapseals (Dilantin 100 mg., phenobarbital 30 mg., desoxyephedrine hydrochloride 2.5 mg.), bottles of 100; **for the petit mal triad:** MILONTIN® Kapseals (phensuximide, Parke-Davis), 0.5 Gm., bottles of 100 and 1,000 and Suspension, 250 mg. per 4 cc., 16-ounce bottles. CELONTIN® Kapseals (methsuximide, Parke-Davis), 0.3 Gm., bottles of 100. ZARONTIN® Capsules (ethosuximide, Parke-Davis), 0.25 Gm., bottles of 100.

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News and Notes

Other Institute News

Business Administrators

The 300 members of the American Society of Mental Hospital Business Administrators held their third annual meeting immediately before the Omaha MH Institute. Mike Gorman, executive director of the National Committee Against Mental Illness, opened the proceedings with a speech on *Action for Mental Health*. New officers installed at the Society's annual banquet were Joseph Greco, St. Louis, Mo., chairman of the board; Carl A. Yopp, Little Rock, Ark., president; R. A. Clelland, Phoenix, Ariz., president-elect; Delbert Mesner, Omaha, Neb., secretary; and C. P. O'Connell, Middletown, N. Y., treasurer. The Society honored retiring board chairman Alexis Tarumianz, Wilmington, Del., as one of its founders, and bestowed honorary memberships on Carl Applegate, Sacramento, Cal., for outstanding service; and on Walter E. Barton, M.D., president of the APA. MHS acts as secretariat for the society.

Medical Superintendents

Approximately 100 members of the recently organized Association of Medical Superintendents of Mental Hospitals met while in Omaha to discuss mutual problems and to exchange opinions of the MHI theme. They also formed committees to consider and evaluate the report of the Joint Commission on Mental Illness and Health. The officers of the new association for the coming year are: Archie Crandell, M.D., medical superintendent, State Hospital, Greystone Park, N. J., president; M. Duane Sommerness, M.D., medical superintendent, State Hospital, Traverse City, Mich., president-elect; Frank Smith, M.D., medical superintendent, State Hospital, Larned, Kansas, treasurer; and Charles Belcher, M.D., State Hospital, Winnebago, Wis., secretary.

AAVSC Holds First Meeting

Before the Institute, members of the newly organized American Association of Volunteer Services Coordinators held their first annual meeting. They approved their constitution and by-laws and elected officers and regional representatives for the next two years. The officers

Mental Hospitals Reprint Service

Readers frequently request reprints of articles in *Mental Hospitals* for distribution to others for various educational and informational purposes. The price list and order form below have been devised to simplify the procedure for obtaining reprints. Since it is not economical to reprint less than 100 copies, the minimum price is based on that number. Reprints are exactly the same size as the originals in the magazine and take the same number of pages. Prices quoted include handling and shipping costs. *Please enclose a check or money order for the exact amount with your order.* Delivery will take approximately three weeks.

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For articles which have pages with pictures and pages without pictures combine above prices. For example:

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QUARTERLY CALENDAR

APA ANNUAL MEETINGS

1962 May 7-11, Royal York Hotel, Toronto, Canada (118th)
1963 May 6-10, Chase-Park Plaza Hotel, St. Louis, Mo. (119th)

APA MENTAL HOSPITAL INSTITUTES

1962 Sept. 24-27, Americana Hotel, Miami Beach, Fla. (14th)
1963 Sept. 23-26, Sheraton-Gibson Hotel, Cincinnati, Ohio (15th)
1964 Sept. 28-Oct. 1, Hotel to be announced, Boston, Mass. (16th)

OTHER APA MEETINGS

Council Meeting, November 24-25, APA Central Office, Washington, D.C.
Divisional Meeting, November 10-12, Hotel New Yorker, New York, N. Y.
Divisional Meeting, November 16-18, Schroeder Hotel, Milwaukee, Wis.
Executive Committee Meeting, January 15, 1962, APA Central Office, Washington, D.C.
Regional Research Meeting, January 19-20, 1962, Los Angeles, Cal. (Inq. Dr. Edward Stainbrook, 1934 Hospital Pl., Los Angeles, 33, Cal.)

CANADIAN MENTAL HEALTH SERVICES INSTITUTE

1962 January 15-18, Chateau Laurier Hotel, Ottawa, Ontario (2nd) (Inq. Dr. V. E. Chase, Canadian Psychiatric Assn., Suite 103, 225 Lisgar St., Ottawa, 4, Ontario)

OTHER PROFESSIONAL MEETINGS

AMERICAN OCCUPATIONAL THERAPY ASSOCIATION, Annual Meeting, *November 5-11,* Sheraton-Cadillac Hotel, Detroit, Mich. (Inq. Miss G. M. Gleave, 3349 LaSalle St., Racine, Wis.)

ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICERS, Annual Meeting, *November 8-10,* Washington, D.C. (Inq. Dr. A. C. Offutt, 1330 W. Michigan St., Indianapolis 7, Ind.)

GROUP FOR THE ADVANCEMENT OF PSYCHIATRY, Fall Meeting, *November 9-12,* Hotel Berkeley Carteret, Asbury Park, N. J.

NATIONAL ASSOCIATION FOR MENTAL HEALTH, Annual Meeting, *November 15-18,* Hotel Deauville, Miami, Fla.

ASSOCIATION FOR RESEARCH IN NERVOUS AND MENTAL DISEASE, Annual Meeting, *December 8-9* (Inq. Dr. Rollo J. Masselink, Sec., 700 W. 168th St., New York 32, N. Y.)

AMERICAN PSYCHOANALYTIC ASSOCIATION, Fall Meeting, *December 8-10,* Biltmore Hotel, New York, N. Y.

ACADEMY OF PSYCHOANALYSIS, Midwinter Meeting, *December 9-10,* New York, N. Y. (Inq. Dr. Joseph H. Merin, 125 E. 65th St., New York 21, N. Y.)

AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY, Examination for certification in P&N, *December 11-12,* New York, N. Y. (Inq. Dr. D. A. Boyd, Jr., 102 2nd Ave., S. W., Rochester, Minn.)

AMERICAN ASSOCIATION FOR THE ADVANCEMENT OF SCIENCE, Annual Meeting, *December 26-31,* Denver-Hilton Hotel, Denver, Colo.

ASSOCIATION FOR PSYCHIATRIC TREATMENT OF OFFENDERS, Annual Meeting, *January 17, 1962,* Academy of Sciences, 2 E. 63rd St., New York, N. Y.

ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF CANADA, Annual Meeting, *January 18-20, 1962,* Chateau Laurier Hotel, Ottawa, Ont., Canada

NATIONAL ASSOCIATION OF PRIVATE PSYCHIATRIC HOSPITALS, Annual Meeting, *January 22-24, 1962,* Colony Beach Resort, Sarasota, Fla.

AMERICAN GROUP PSYCHOTHERAPY ASSOCIATION, Annual Meeting, *January 24-27, 1962,* New York, N. Y.

are: Miriam Karlins, Minn., president; Mickey Umba, Conn., vice president; Blakey Adams, La., treasurer; Katheryn Springer, Ore., corresponding secretary; Nanieve Callahan, Utah, recording secretary; and William Judkins, Minn., parliamentarian and historian. Board members (regional representatives) include Dorothea Benson, R. I.; Glenna Bolstad, Ind.; Jane Hayes, Fla.; Jane Phillips, Ill.; Helen Colburn, Tex.; Edward Lamb, Cal.; and Robert G. Menning, Ia. Approximately 60 people registered for the Omaha meeting, and the new association has received 120 applications for membership.

Medical Self-Help Training

A new program to teach American families how to survive a national emergency and how to meet their own health needs if deprived of a physician's services has been introduced to medical and health professions by the U. S. Public Health Service in cooperation with the American Medical Association.

The Medical Self-Help Training Program consists of two parts: a reference manual to serve as a resource document and a formal training course of 12 lessons to be taught in a 16-hour period. A training kit has been developed for the training course to make instruction as simple and as standardized as possible.

It is expected that each state will establish a medical self-help committee to supervise the program and to distribute and control usage of the training kits. Successful implementation of the program at the local level will depend on the active participation and support of physicians and members of all the health professions.

CORRECTION

In the September 1961 issue of *Mental Hospitals,* the degree of Mrs. L. Rydman, co-author of the article "Nursing Routines: Masters or Servants?" was erroneously printed as R. N. Mrs. Rydman is a registered psychiatric nurse (R. P. N.).

PEOPLE and PLACES

MINNESOTA: **Richard E. Bartman, M.D.,** has been appointed assistant director, Division of Medical Services, Minnesota Department of Public Welfare, St. Paul. Dr. Bartman served as assistant superintendent, Sonoma State Hospital, Eldridge, Cal., prior to his new position.

John Stocking, a licensed hospital administrator, has been appointed assistant hospital superintendent at Cambridge State School and Hospital, Cambridge. Previously, Mr. Stocking was assistant executive director of Midway and Mounds Park Hospitals, St. Paul.

HERE & THERE: **George L. Wadsworth, M.D.,** superintendent of Clover Bottom Hospital and School at Donelson, Tenn., has resigned effective Dec. 1. Dr. Wadsworth has accepted a position as assistant commissioner and head of the Bureau of Mental Retardation in the Ohio Department of Mental Health.

Jaime Goldfarb, M.D., a native of Buenos Aires, Argentina, has been named clinical director of Pineland Hospital and Training Center, Pownal, Maine.

The headquarters office of the **National Society for Medical Research** has been moved from Chicago, Ill., to 111 Fourth St., S.E., Rochester, Minn. **Hiram E. Essex, M.D.,** of the Mayo Foundation for Medical Education and Research, located in Rochester, is the Society's new president.

Wilson T. Sowder, M.D., former director of the Florida State Health Department, has been appointed chief of the Public Health Service's new Office of Aging. Dr. Sowder will be responsible for coordinating the many health and medical activities in this field.

Reverend Archibald F. Ward, Jr., Ph.D., has been appointed to the newly established position of director of chaplaincy studies at

St. Elizabeths Hospital, Washington, D. C. Prior to this appointment, Rev. Ward was director of patient activity services at State Hospital South, Blackfoot, Idaho.

John C. Eberhart, M.D., has joined the staff of the National Institute of Mental Health, Bethesda, Md., as associate director for intramural research. Dr. Eberhart will direct the Institute's research program that deals with the causes, diagnosis, treatment, and prevention of mental disorders. From 1947 to 1954, Dr. Eberhart served on the staff of NIMH and, at the time he left the Institute, was chief of the Research Grants and Fellowships Branch.

George Jackson, M.D., director of institutions in Kansas, will resign in December to become superintendent, Arkansas State Hospital. Dr. Jackson previously held this position from 1946 to 1951. **Richard Meadows, M.D.,** assistant director, will succeed Dr. Jackson as acting director.

Rodney Pelton has been appointed supervising psychiatric social worker in the Broome County Mental Health Clinic, N. Y. Mr. Pelton was formerly on the staff of the Battle Creek Child Guidance Clinic, Battle Creek, Mich.

S. E. Jensen, M.D., of Weyburn, Saskatchewan, Canada, has been appointed the first director of the Mental Health Clinic, York County Health Unit, Ontario.

Carlos A. Recio, M.D., has been named clinical director of Massillon State Hospital, Ohio. Previously, Dr. Recio was clinical director at Western State Hospital, Staunton, Va.

Robert T. Hewitt, M.D., formerly chief of the Hospital Consultation Service, National Institute of Mental Health, Bethesda, Md., succeeded **Warren T. Vaughan, Jr., M.D.,** as director of mental health programs for the Western Interstate Commission for Higher Education in Boulder, Colo. Dr. Vaughan has entered private practice in California.

Dougherty County Mental Health Clinic, Ga., began receiving patients in September. The new clinic is a nonprofit psychiatric outpatient clinic for the diagnosis and treatment of emotional disorders. **Allan W. Russell** is executive director and **Otis J. Woodward, Jr., M.D.,** is the clinic's psychiatric consultant.

Thomas H. Hogshead, M.D., formerly with the Dupont Co., Wilmington, Del., succeeded **Cecil G. Stillinger, M.D.,** as superintendent of the New Mexico State Hospital, Las Vegas. Dr. Stillinger is the new clinical director of Broughton State Hospital, Morganton, N. C.

Sherman N. Kieffer, M.D., formerly chief, Psychiatric Services and director, Psychiatric Residency Training at the U. S. Public Health Service Hospital, Lexington, Ky., is now deputy medical officer in charge of the Fort Worth Public Health Service Hospital in Texas. The new director of nursing at the hospital is **Mrs. Lydia K. Oustaian,** who was previously the director of nursing service at the U.S.P.H.S. Hospital in Lexington, Ky.

Jack Masur, M.D., director of the Clinical Center, National Institutes of Health, is the new president of the American Hospital Association.

Richard S. Iverson, M.D., of Ogden, Utah, has been appointed the first director of the new Weber County mental health program. Dr. Iverson will serve on a part-time basis and continue his private psychiatric practice.

HONORED:**Herman C. B. Denber, M.D.,** director of psychiatric research, Manhattan State Hospital, N. Y., and associate clinical professor at the New York Medical College, was recently honored by the French Government. Dr. Denber was decorated and made a *Chevalier de l'Ordre de la Sante* in recognition of his efforts toward increasing scientific and cultural exchanges between French and American psychiatrists.

DEATH: **Rudolph J. Depner, M.D.,** medical director of the Milwaukee County Asylum, Wis., and formerly assistant commissioner of mental hygiene in Maryland, died September 27.